S. HRG. 103–985

1994 NOMINATIONS FOR THE DEPARTMENT OF VETERANS AFFAIRS

Y 4. V 64/4: S. HRG. 103-985

1994 Nominations for the Department...

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

THE NOMINATIONS OF R. JOHN VOGEL, TO BE UNDER SECRETARY FOR BENEFITS, AND KENNETH W. KIZER, M.D., M.P.H., TO BE UNDER SECRETARY FOR HEALTH

JANUARY 26 AND SEPTEMBER 13, 1994

Printed for the use of the Committee on Veterans' Affairs

GOVERNMENT DOCUMENTS DEPARTMENT

APR 14 1995

U.S. GOVERNMENT PRINTING OFFICE

88-271 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046899-X

S. HRG. 103-985

1994 NOMINATIONS FOR THE DEPARTMENT OF VETERANS AFFAIRS

Y 4. V 64/4: S. HRG. 103-985

1994 Nominations for the Department...

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

THE NOMINATIONS OF R. JOHN VOGEL, TO BE UNDER SECRETARY FOR BENEFITS, AND KENNETH W. KIZER, M.D., M.P.H., TO BE UNDER SECRETARY FOR HEALTH

JANUARY 26 AND SEPTEMBER 13, 1994

Printed for the use of the Committee on Veterans' Affairs

SUPERINTENDENT OF DOCUMENTS
APR 14 1995

U.S. GOVERNMENT PRINTING OFFICE

88-271 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046899-X

COMMITTEE ON VETERANS' AFFAIRS

JOHN D. ROCKEFELLER IV, West Virginia, *Chairman*

DENNIS DeCONCINI, Arizona
GEORGE J. MITCHELL, Maine
BOB GRAHAM, Florida
DANIEL K. AKAKA, Hawaii
THOMAS A. DASCHLE, South Dakota
BEN NIGHTHORSE CAMPBELL, Colorado

FRANK H. MURKOWSKI, Alaska
STROM THURMOND, South Carolina
ALAN K. SIMPSON, Wyoming
ARLEN SPECTER, Pennsylvania
JAMES M. JEFFORDS, Vermont

JIM GOTTLIEB, *Chief Counsel / Staff Director*
JOHN H. MOSEMAN, *Minority Staff Director / Chief Counsel*

(II)

CONTENTS

JANUARY 26, 1994

Page

Nomination of R .John Vogel to be Under Secretary for Benefits 1

STATEMENTS BY COMMITTEE MEMBERS

Chairman John D. Rockefeller IV 26
Senator Daniel K. Akaka 27
Senator Ben Nighthorse Campbell 2
Senator Bob Graham 6
Senator Frank H. Murkowski 1
Prepared statement of Senator Murkowski 28
Senator Strom Thurmond 29

WITNESS

Vogel, R. John, nominee for Under Secretary for Benefits, Department of Veterans Affairs 4
Prepared statement of Mr. Vogel 29

SEPTEMBER 13, 1994

Nomination of Kenneth W. Kizer, M.D., M.P.H., to be Under Secretary for Health 8

STATEMENTS BY COMMITTEE MEMBERS

Chairman John D. Rockefeller IV 8
Prepared statement of Chairman Rockefeller 127
Senator James M. Jeffords 129
Senator Frank H. Murkowski 10
Senator Strom Thurmond 128

WITNESS

Kizer, Kenneth W., M.D., M.P.H, nominee for Under Secretary for Health, Department of Veterans Affairs 11
Prepared statement of Dr. Kizer 130

APPENDICES

Appendix 1.—Nomination of R. John Vogel
Prepared statements of Committee members 26
Prepared statement of witness 29
Statement: Johnson, Richard W., Executive Director of Government Affairs, Non Commissioned Officers Association of the United States of America 31

Written questions to Mr. Vogel, and the responses:
Prehearing questions from Chairman Rockefeller 32
Posthearing questions from:
Chairman Rockefeller 86
Senator Daschle 102
Senator Jeffords 106
Senator Murkowski 106
Senator Thurmond 120
Part I of statement for completion by Presidential nominees 121

Appendix 2.—Nomination of Kenneth W. Kizer, M.D., M.P.H.
Prepared statements of Committee members 127
Statement of the Hon. Dianne Feinstein, a U.S. Senator from the State of California 129
Prepared statement of witness 130
Written questions to Dr. Kizer and the responses:
Prehearing questions from Chairman Rockefeller 131
Posthearing questions from:
Senator Akaka 156
Senator Murkowski 158
Senator Thurmond 159
Part I of statement for completion by Presidential nominees 161

NOMINATION OF R. JOHN VOGEL TO BE UNDER SECRETARY FOR BENEFITS IN THE DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, JANUARY 26, 1994

U.S. SENATE
COMMITTEE ON VETERANS' AFFAIRS
Washington, D.C.

The Committee met, pursuant to notice, at 10:17 a.m. in SR–418, Russell Senate Office Building, Hon. John D. Rockefeller IV (Chairman of the Committee) presiding.

Present: Senators Rockefeller, Graham, Campbell, and Murkowski.

Senator MURKOWSKI [assuming Chair]. I'm going to, on behalf of the Chairman, call the meeting of the Senate Committee on Veterans' Affairs to order, and I'm going to have a brief opening statement. Senator Rockefeller will be here—he's on his way—and, of course, I'll turn the hearing over to him upon his appearance.

I'm going to have Mr. Vogel sworn in, but I think I'll proceed with opening statements first.

OPENING STATEMENT OF SENATOR MURKOWSKI

Very briefly, this Committee, and the Senate as a whole, are going to be facing a number of critical issues during the coming year. Much of our attention is going to be directed toward health care issues, including just where VA is going to fit in if reforms are enacted. Since we're going to be focusing so much on health care in the coming year, I'm very pleased that this hearing—coming as it does on the second day of the session—affords us opportunity to reaffirm the importance of VA's benefits system. In addition to attention to health care issues, we will see to it that the VA benefits delivery system will be a prime topic of interest for the Committee to follow during the coming year.

As we all know, VA has a substantial backlog of claims waiting to be processed, and it's my understanding that there's growing concern because the claims backlog appears to be increasing at a rapid rate. This is unacceptable. By all appearances, the backlog problem will get worse before it gets better. I'm told that over the next 2 years it will grow from about 550,000 cases to an astonishing 800,000 cases. Staff counsel on both sides are nodding their heads, so clearly we have a problem.

The nominee before us this morning certainly faces some tough tasks in dealing with this backlog. We know that VA faces more claims to process. We also know that the processing of individual

claims has become more complex. Some might say it's perhaps over-lawyered, if I can coin a term. Some of you are nodding your heads on that one, too. That's a good sign. We also know that VA will not likely be receiving any significant increases in staffing to deal with the backlog and that VA must, therefore, learn to do more with less.

I'm pleased that we have before us a man as dedicated and as experienced as Mr. Vogel. His prepared testimony appears to recognize that VA must change how it does business. I agree VA must work smarter if it's ever to get out of the caseload hole in which it finds itself, and I'm sure Mr. Vogel will address that issue this morning.

John, you're certainly a brave man to take on this job. I think it's clear from your background, having worked at nearly every step and stage of the adjudication process, that you know and understand probably better than most VA's benefits system. We in Congress will look to you for leadership. We'll also look to you for concrete suggestions for appropriate legislative changes, if such are needed to assist you in getting control of the adjudication mess that we must face together. We want to help you. Our constituents and your clients—the Nation's veterans—deserve nothing less.

So, Mr. Vogel, I welcome you before the committee and would ask Senator Campbell if he has a statement that he would care to make at this time.

[The prepared statement of Senator Murkowski appears on page 28.]

OPENING STATEMENT OF SENATOR CAMPBELL

Senator CAMPBELL. Thank you, Mr. Chairman. I don't have a formal written statement. I have another committee hearing going on, but I did want to come down and express my support for John Vogel as the Under Secretary for Benefits. I know that he'll bring a very strong commitment to do his very best for our American veterans in a time of declining budgets, where tough choices have to be made. I know that's going to be very challenging for him.

I had an opportunity to spend a couple of days with John and Secretary Brown a couple of months ago in Colorado, where we signed the first memorandum of understanding with Indian tribes that will allow Indian veterans the opportunity to get VA loans, just like their non-Indian counterparts. In the past, they've never been able to do that, as you know, because they cannot put trust land up as collateral to insure those loans.

So during that 2 days that we spent at the Southern Ute Reservation in which he traveled a little bit in the southwest part of our State of Colorado, I found him to be very knowledgeable and very committed, and I think he's going to do a very, very fine job and just wanted to express my support for his nomination.

Thank you.

Senator MURKOWSKI. Thank you very much, Senator.

I think it's important that the record note the association with VA that John Vogel has had starting, I believe, in 1975.

Mr. VOGEL. 1968, sir.

Senator MURKOWSKI. OK. Well, you can fill us in. I guess you're correct. It says "See the attached sheet," and I didn't look at the attached sheet, so I started your career in 1975. You've been Adjudication Officer, Regional Officer, Chief Benefits Director, Special Field Operations Rep, Medical Center Director, Deputy Under Secretary for Benefits. So I think Senator Campbell would agree that we have a man of extraordinary experience and expertise.

We have a statement from Senator Thurmond. I would ask unanimous consent that his statement be entered into the record as if read.

[The prepared statement of Senator Thurmond appears on page 29.]

Senator MURKOWSKI. If we may, in view of the fact that we have a vote at 10:30, proceed with the swearing in. I would ask that John Vogel stand and take the oath, raising his right hand.

Do you swear or affirm that the testimony you will give at this hearing and any written answers or statements you provide in connection with this hearing will be the truth, the whole truth, and nothing but the truth?

Mr. VOGEL. I do.

Senator MURKOWSKI. Thank you. Please sit down.

Chairman ROCKEFELLER [assuming Chair]. Well, good morning. Happy New Year.

Senator MURKOWSKI. I just swore in the witness. We've just got time for your opening statement, and then we've got a vote.

Chairman ROCKEFELLER. And seeing how he was from West Virginia, we decided to go ahead and support him. [Laughter.]

Senator MURKOWSKI. You know, it amazes me how I can get down from Alaska in time for the hearing, and you're just coming from West Virginia. [Laughter.]

Chairman ROCKEFELLER. No. In fact, I was just coming—and I apologize to you, Senator Murkowski, and to my colleagues and to John Vogel—from a health care event where I was required to be. And I won't, out of deep respect for my colleagues, and deep fear of my colleagues, give my opening statement, but submit it for the record.

But I do want to say that President Clinton has obviously shown his confidence in John Vogel, and also that John has completed the Committee Questionnaire for Presidential Nominees and responded to prehearing questions. All of that is done, and all of that will appear in the hearing record. Also included will be a letter from the Office of Government Ethics acknowledging that he's in compliance with laws and regulations governing conflicts of interest. And I've reviewed the FBI report on John Vogel and found it one of the most boring that I've ever read in my life. [Laughter.]

Mr. VOGEL. I never got in trouble.

Chairman ROCKEFELLER. And, as obviously everybody knows, he's being considered for the position of Under Secretary for Benefits at a time when the Veterans Benefits Administration is truly at a crossroad. This job brings with it enormous challenges, tremendous heat and pressure, a lot of anxiety.

Your oath has been administered, and I look forward to hearing your testimony. And I'm glad you're from West Virginia, but I won't let that influence my vote.

[The prepared statement of Chairman Rockefeller appears on page 26.]

STATEMENT OF R. JOHN VOGEL, NOMINEE TO BE UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Mr. VOGEL. Thank you, Mr. Chairman. It's an honor to appear before you today and be considered by you and this Committee for confirmation as the Under Secretary for Benefits at the Department of Veterans Affairs.

I've submitted a written statement for the record, but in summarizing that, what I'd like to say is that I know what the problems are, as you do. I share your concern, and I understand what needs to be accomplished, and together with the fine people in the Veterans Benefits Administration, I am convinced that we can turn it around. We'll focus on the reengineering of our work processes, on modernization of our ADP systems, and on the training of our employees. Our veterans deserve the best. We'll give it our best; I will give it my best.

I'm ready and prepared to answer your questions, Mr. Chairman.

[The prepared statement of Mr. Vogel appears on page 29.]

Chairman ROCKEFELLER. John, that was a pretty long statement. [Laughter.] I defer to my colleague from the State of Alaska.

Senator MURKOWSKI. John, I want to commend you for your opening statement. I think it was to the point and appropriate and, based on your qualifications and experience, absolutely adequate. But the problem is how we're going to address this backlog, and that would be, I think, of paramount interest to those that are with us today as well as my colleagues.

Mr. VOGEL. Senator Murkowski, we're going to address that on a number of fronts. We are actively working on reengineering the way we conduct our business. In past years, a process of incrementally adding value to a claim as it went through a system worked fairly well. The claims were fairly straightforward. We had a sort of an assembly line approach, and it served us well. We now deal in many more issues per claim, and we deal in very complicated, complex issues, such as radiation exposure, Agent Orange, mustard gas, post-traumatic stress disorder, and so on.

So we found that we must break the system down in a different way, adding more decision makers into the system and less people who just pass paper back and forth. Our modernization will allow us to minimize the handing off and the processing of paper which don't lead the claims to outcomes. We've put a lot of effort into training our people in order to address those complex issues specifically.

Recently a report was given to me by a panel called, euphemistically, the Blue Ribbon Panel on Claims Processing, composed of our people, people from the Office of the Board of Veterans' Appeals, the Office of General Counsel, and a number of the major veterans service organizations. They made a proposal to

me, accepted by me and endorsed by Secretary Brown, to do 43 specific things that we know, if done, will assist us in bringing better timeliness and better quality service to our veterans. We have the will, we certainly have the talent, and I think we can do it.

Senator MURKOWSKI. Recognizing we've had more people get out of the service, and the Court of Veterans Appeals decisions have resulted in more remands, you therefore have a large backlog. But has there been a reluctance, or an inability or budget constraints, that have made it more difficult to automate the claim process? With computerization, it would seem that this backlog could be addressed.

Mr. VOGEL. Unfortunately, Senator Murkowski, we've had to make some deferrals putting in ADP systems that we need based on some questions raised about whether we really had these plans in sync and whether they really were going to be helpful. That's hurt us, no question about that. We're now installing what we call Stage I of our modernization. About 20 of our regional offices have it installed now, most of the larger ones, and by the end of this fiscal year, we'll have a platform built that gives us more computing capacity and puts into place a number of labor-saving systems which will serve us very well. We'll then proceed with the implementation later of more sophisticated and helpful programs.

The present system we have has been around for nearly 20 years, and it's fragile. It doesn't serve us very well. We spend a lot of resources just kind of maintaining the system. Our new system will leave that behind us. We have far too many people doing the systems maintenance.

Senator MURKOWSKI. Does being so far behind—what did we say, soon approaching 800,000 cases—lead to morale problems among your people? Do they go to work in the morning and find out at the end of the day that they're another 3,000 cases behind?

Mr. VOGEL. It's a challenge to our personnel. I think they do in fact from time to time become a little demoralized. We know, as perhaps some other people administering Federal programs, that every action we take, there's a veteran on the other end or there's a widow or there's an orphan. They know that, and that tends to keep their chins up. Also, there's a great deal of anticipation for the installation of these modern computing systems, and they're getting trained like never before, and that buoys their spirit. We're OK on the morale front.

Senator MURKOWSKI. Thank you, Mr. Vogel.

I have no further questions, Mr. Chairman.

Chairman ROCKEFELLER. Senator Campbell, I want to call on you now, but then I want to make sure that Bob Graham is understood by the audience to be the person whose State John Vogel really comes from. John was born in Wheeling, WV, but he lives in Florida, and I think that Bob Graham might have wanted to introduce you.

So, Ben, you were here first, so—

Senator CAMPBELL. Mr. Chairman, I did have an opportunity to make an opening statement, and I am absolutely committed to supporting John Vogel, and since we do have a vote coming up, I would defer to my friend and colleague from Florida.

Chairman ROCKEFELLER. OK. Bob.

OPENING STATEMENT OF SENATOR GRAHAM

Senator GRAHAM. Mr. Chairman, I appreciate the courtesy of Senator Campbell, and this is both in the nature of an opening statement and an observation on the responsibilities that Mr. Vogel is about to undertake. I am very pleased that he has been nominated by President Clinton for the Under Secretary of Veterans Affairs for Benefits. I am aware of the distinguished career that Mr. Vogel has had in the Department, including a tenure as Chief Benefits Director from 1985 to 1990. In more recent years, Mr. Vogel has been at the Bay Pines Veterans Hospital in Pinellas County, Florida.

Mr. Chairman, as I mentioned to you yesterday, on January 5, I had an opportunity to spend a day at the Bay Pines Veterans Medical Center. Mr. Vogel was not there that day. I think he was in Washington preparing for today's hearing. But I was impressed with the impact that Mr. Vogel made while he was at Bay Pines. The professionalism of the staff, the very laudatory comments by the veterans who were being served there, speak of his leadership.

I was also impressed with the fact that Bay Pines is more than a hospital. In many ways, it is a caring community which has a genuine outreach and understanding of the needs of veterans and then an appropriate means of meeting those needs. As an example, the hospital has developed a very extensive outreach to the homeless veterans, including a program in which they hired the largest public facility in Pinellas County—the Thunderdome, which is the large covered facility that someday will house major league baseball in the Tampa Bay area—and encouraged homeless veterans to come for counseling and other services that were available. While I was at Bay Pines on that Wednesday, I met a number of veterans who had become aware of the types of services that were available and were availing themselves of it as a result of that outreach.

I think that is illustrative of the attitude that Mr. Vogel brings to his responsibility. I believe that he understands that the approach of the Federal Government to dealing with its veterans who have defended this Nation is a total one and that benefits of an economic nature, benefits of a medical nature, and the other relationships are part of a comprehensive effort to deal with individual human beings who have served this Nation and today have genuine problems for which this Nation is now paying part of its respect, tribute, and debt to these people by being a partner in resolving.

Mr. Vogel is an important part of that partnership, and I highly recommend him for quick confirmation as Under Secretary for Benefits.

[The prepared statement of Senator Graham appears on page 27.]

Chairman ROCKEFELLER. Thank you, Senator Graham.

In closing this nomination hearing, I just want to say one thing. You probably have one of the toughest jobs—and you will get it—one of the toughest jobs in the U.S. Government. That having been said, people understand that you're walking into something which is hard, which people get angry about, which is at the top of the list of many veterans in terms of their frustration.

For you to take this job—and you will be confirmed, as I mentioned—is a wonderful first step, but as soon as you're in the job, John, remember that we are an oversight committee, and our job is to deliver for the veterans of the United States of America. So I think there's going to be inevitably, and probably constructively, some conflict between this Committee and you as we proceed.

I don't think it's just a matter of computers, redoing all the system, and retraining. I think it's a question of starting all over again in some respects, figuring how we're going to do this, and how we're going to do it right. I think you've got one of the most massive problems, one of the most fundamentally difficult problems facing you, of anybody who works for the United States Government, and I just flat out mean that.

We're going to be behind you in your confirmation. We're going to be behind you in your work. But I want to remind you that we are first and foremost an oversight committee and that this is an area that veterans care about, this is an area that this Committee cares about, an area that this Chairman cares about, and we're going to do our job, just as you're going to do your job.

So I thank everybody for coming, unless there are more questions.

I thank you, John, and I wish you well.

This hearing is adjourned.

[Whereupon, at 10:37 a.m., the Committee adjourned, to reconvene at the call of the Chair.]

NOMINATION OF KENNETH W. KIZER, M.D., TO BE UNDER SECRETARY FOR HEALTH FOR THE DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, SEPTEMBER 13, 1994

U.S. SENATE
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC.

The Committee met, pursuant to notice, at 3:10 p.m. in room SR–418, Russell Senate Office Building, Hon. John D. Rockefeller IV (Chairman of the Committee) presiding.

Present: Senators Rockefeller and Murkowski.

Chairman ROCKEFELLER. The Chairman of this Committee apologizes to the former Chairman of this Committee and ranking Republican member of this Committee, to Dr. Kizer, and to all for the late start. I cannot say that this is unprecedented, but it is entirely embarrassing to me and I apologize.

Senator MURKOWSKI. If I could have found Dr. Kizer, I was prepared to start without you.

[Laughter.]

Senator MURKOWSKI. You had him locked up in the back room.

Chairman ROCKEFELLER. Oh, that's right; we had the witness, didn't we?

Senator MURKOWSKI. That's right. I couldn't do a thing about it.

Well, the recess is over so it's back to reality and to Haiti and all those things.

Chairman ROCKEFELLER. That's right. That's right.

I want to give a statement and then, Frank, maybe you'll have something to say, too. I explained to Dr. Kizer that confirmation hearings are not always well attended.

OPENING STATEMENT OF CHAIRMAN ROCKEFELLER

Today's confirmation hearing for Dr. Kenneth Kizer marks a turning point for VA and for veterans across this country. For more than a year and a half now, VA has lacked any real leadership for its medical programs. We hope to rectify that situation.

The VA medical system is the largest health care system in this Nation, and it is one of the largest in the world. The fact that it's been leaderless for this long is really quite extraordinary. It is a program with many strengths, especially for veterans who are blind, who have spinal cord injuries, amputations or PTSD. It is also a program that has many weaknesses. One major weakness is that it lacks resources that it needs to provide medical care for all the

Nation's veterans who would like to obtain care there. However, there are also weaknesses that are created by a bureaucracy in Washington that has failed to treat veterans with the respect and the fairness that they deserve.

The VA Under Secretary for Health is one of the most important public servants in Washington. It is one of the most difficult, complex, and challenging jobs in Washington. The next Under Secretary will guide the VA medical system at a time when it desperately needs a leader, desperately needs a leader with the vision to guide VA into the next century under what are becoming very, very difficult circumstances.

It is outrageous that this position has been essentially unfilled since February 1993, and as a result, the pressures and the expectations on the Under Secretary will be even more enormous. Dr. Kizer, if you are confirmed, you will be the first person in that position to come from outside the VA system. While most of us believe that this will bring a much needed fresh perspective, it also means that it could be that much harder for you, unless you are skillful, to get VA moving in new directions and doing so as soon as possible. In addition, you would inherit a system that has been controlled basically by others in the absence of an Under Secretary, and one that has been much too reluctant, in my view, to delegate authority to directors of the 171 VA medical centers across this country.

For the past year, VA and this Committee have been concentrating much of our efforts on health care reform, as I'm sure you know. Our goal has been to keep VA an independent entity, while strengthening it and reforming it in the context of something called national health care reform. The ultimate success or failure of these efforts are as yet unknown, because they depend so entirely on our ongoing struggle to pass a meaningful health care reform bill.

But regardless of the outcome of that battle—and I remain optimistic that we will come out of this Congress with good health care reform—the VA medical system needs strong leadership. Whether we do or whether we don't, VA needs strong medical leadership. VA also needs a leader who is strong enough to delegate authority to others, and a leader who is strong enough to take on his or her superiors when that is necessary. We need leadership in the medical field, and my questions will all be focused on that point. Unfortunately, as I indicated, we've lacked that leadership for many years. The purpose of this confirmation hearing is to convey our concerns about the need for dramatic changes in the VA medical system, and give you the opportunity to let us know how you plan to meet those challenges.

[The prepared statement of Chairman Rockefeller appears on page 127.]

Chairman ROCKEFELLER. Those are my remarks. Senator Murkowski may have some remarks, and after that I will administer an oath to you, Dr. Kizer.

Senator MURKOWSKI. Thank you, Mr. Chairman. I, too, want to welcome you, Dr. Kizer, and acknowledge your family that I believe is in the audience.

Dr. KIZER. That's correct.

Senator MURKOWSKI. Would you like to introduce your family?

Chairman ROCKEFELLER. Yes. Dr. Kizer, please do.

Dr. KIZER. If I may, Mr. Chairman and Senator Murkowski. This is my wife, Suzanne; my youngest daughter, Kimberly; and my oldest daughter, Kelly.

[Applause.]

Senator MURKOWSKI. You have your ticket to eternity with your lovely daughters. They bear a striking resemblance to their mother.

[Laughter.]

Dr. KIZER. I see problems down the road.

[Laughter.]

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Let me acknowledge, Chairman Rockefeller, your efforts and those of the staff for expediting the hearing and the vote on the nomination. As you pointed out, it has been over a year and a half—time does move fast around here—since VA has had an Under Secretary for Health. That is really too long of a time, as you've indicated, Mr. Chairman, to have passed between the departure of the predecessor and your nomination to head an organization that millions of veterans look to for their health care.

So I applaud you for agreeing, Dr. Kizer, to serve as head of the Veterans Health Administration. The challenges you will face will be daunting. I have, on floor debate with the Chairman, suggested that I think you can stop a train in a mile or two and a tanker in 5 to 6 miles, but trying to stop the direction of VA and turn it around some would suggest is impossible. But you have that responsibility, Doctor, and we look forward to seeing your efforts to turn it around because certain aspects of VA do need turning.

You are going to be under constraints, and some of those constraints will undoubtedly appear to be crushing at times. The responsibilities you will be assuming include questions involving the life and death, and the welfare, of our veterans. And sadly, your reward is likely to include a generous measure of second guessing. Probably some of that may come from this Committee, from the Hill, and from your own staff as well. But that's what responsibility and leadership are all about.

When you are confirmed—and I'm sure you will be confirmed—you will assume responsibility for the Veterans Health Administration at a time when American health care is remaking itself. The practice of medicine is changing at a pace that can hardly be measured, much less explained. In any event, the transition away from hospital care to outpatient care may be only the most visible example of this change. The organization of medicine is also undergoing profound changes as the Federal Government debates the funding and administrative aspects of health care and as the States individually enact health care reform legislation. So VA must adapt to this changing environment if it is to continue to provide quality care for our Nation's veterans.

You will assume responsibility for laying the foundation for VA's health care system in the 21st century, and the reform associated therewith. At the same time, you are going to have to lead a network

of hospitals constructed to fulfill a vision of health care as it was understood at the end of World War II, which of course was a half century ago. Your success will depend upon your willingness to make significant changes; to ask, in many cases, unpopular questions, to propose bold changes in courses of action. None of these actions is going to be easy. But if things were easy, you probably wouldn't be here.

Many, perhaps most, of your responsibilities and challenges are going to be controversial, but I believe that neither the Congress nor the veterans we serve are satisfied with the status quo. I do not believe that VA can make significant improvements by continuing to do only what it has done previously. If you propose a course towards more ambulatory care, I want you to know that I will strongly support that change. If you propose to integrate VA health care more closely with other community and Federal providers, I will support your actions if it will improve health care for veterans. If you shift the VA focus away from the bricks and mortar of its buildings and towards health care services for veterans, I will applaud your actions. If you transfer authority away from bureaucrats in Washington and to VA leadership in the field, I will stand by your side.

You have chosen to accept a very difficult mission and I commend you for your courage and for your commitment to America's veterans. I look forward, with the Chairman, to hearing your testimony today and welcome you before the Committee.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Murkowski, very much.

As I indicated to you, Dr. Kizer, you will testify under oath. So I would appreciate it if you would stand and raise your right hand. Do you swear or affirm that the testimony that you will give at this hearing and any written statement or answers that you provide in connection with this hearing will be the truth, the whole truth, and nothing but the truth?

Dr. KIZER. I do.

Chairman ROCKEFELLER. Let the record show that the witness said "yes."

Do you want to start off with some questions or do you want me to?

Senator MURKOWSKI. Go ahead. Perhaps he has a statement first.

Chairman ROCKEFELLER. Oh, that would be fair, wouldn't it.

Senator MURKOWSKI. Let's see what he's got to say first.

[Laughter.]

Chairman ROCKEFELLER. Yes.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. KIZER. Thank you, Mr. Chairman and Senator Murkowski.

I am pleased to be here today as President Clinton's nominee to be the Under Secretary for Health in the Department of Veterans Affairs. I am honored to be considered by you for this position.

Mr. Chairman, as you noted, I am coming from outside VA. While I do have significant experience with VA, my professional life has been spent outside of the Veterans Health Administration, and I believe that my presence before you today is an affirmation of both President Clinton's and Secretary Brown's interest in seeing new ideas and new perspectives brought into the Veterans Health Administration.

Mr. Chairman, if I am confirmed to be Under Secretary, I believe that I would bring to this position a mix of relevant private sector and public sector management experience. In particular, I might note that during the more than 6 years that I served as California's top health official, and more recently in my positions with the University of California and with the California Wellness Foundation, I have been very much involved in health care reform issues. Indeed, some of the health care reform activities that I was directly involved with in California have been held out as national models for consideration in the debate on health care reform here in Washington.

I believe that my experience in this regard would be very useful to the Veterans Health Administration as it adapts to the very rapidly changing health care environment that both of you have commented on, and as new paradigms of health services delivery and treatment become the norm.

If the Veterans Health Administration is to provide superior quality health care at an affordable cost in the 21st century, then it must reorient itself. The Veterans Health Administration must become a coordinated system of regional and local integrated networks of health service delivery that provide a seamless continuum of care. Strong ambulatory and long-term care capabilities will be essential and certainly will be among my priorities. State-of-the-art medical informatics and electronic information systems will also be among my priorities. The VA medical care system of the 21st century also needs to be a system that focuses on the entire person, that integrates medical care with other services, and that stresses prevention of illness and health promotion. It also must be a system in which male and female veterans are accorded the same priority and the same sensitivity.

Mr. Chairman, I have kept these remarks very brief so as to maximize the opportunity for some dialog with you and other members who may have questions. Let me just conclude by saying that if I am confirmed, I look forward to an open and productive relationship with you and the Committee, and with other Members of Congress who are not here today. Thank you.

[The prepared statement of Dr. Kizer appears on page 130.]

Chairman ROCKEFELLER. Thank you, Dr. Kizer.

Let me just start out with my main point. I view the fact that you are an outsider to the VA system as a real opportunity. You have not come up from within the ranks, although I think you did some of your training at a VA hospital, did you not?

Dr. KIZER. As is characteristic of many physicians trained in this country, I did have exposure to the VA health system during my training.

Chairman ROCKEFELLER. And the veteran service organizations I think have adjusted to that. That was kind of a novel idea, but I think they've adjusted to that now.

What is going to make you work, if you're confirmed as Under Secretary, and work successfully, is if, in fact, you do take a $16 billion health care system and run it. You will be working in the second largest bureaucracy in the United States Government: 240,000 employees. It is huge. And it is traditionally a kind of top down operation, as Senator Murkowski intimated. It is run top down and people don't like to delegate a lot. That's probably because people don't want to make mistakes, and they feel if they have it in their hands, they are less likely to make mistakes. Well, that's fine if you're running a grocery store; it is a little less good if you're running something called the Veterans Health Administration.

This is a responsibility that I know you will have, the overall management, independence, and responsibility that you will have as Under Secretary if you are confirmed. I am sure that you have discussed this with Secretary Brown and Mr. Gober. But this is something which is very important to me, that the person who has this position in fact runs the medical system, and that you're willing to stand up to people who may be above you, and people who are below you, if you feel that you are right. You are the professional, you're trained, you've been out in the field, you understand the situation.

I would like to get your professional reaction to that in the context of an enormous Federal Government organization.

Dr. KIZER. There are a number of points there that I could respond to, and let me try to respond to some of them, and then we can come back to others if I forget to comment on them.

I think one of the points that you asked is, how do I see my role? In my discussions with both the Secretary and the Deputy Secretary, as well as in some of the written materials about the job description, if you will, it is my understanding and my expectation that the Under Secretary for Health is the chief executive officer of the Veterans Health Administration, and that is the role which I expect to assume if confirmed.

Chairman ROCKEFELLER. Have you discussed that with Jesse Brown and Hershel Gober?

Dr. KIZER. As I indicated, Senator, I have had that discussion. And that is my expectation and my understanding of what they expect.

Chairman ROCKEFELLER. Have they recognized that?

Dr. KIZER. That is my understanding of their comments. And, as I said, my expectation going into the job is that the Under Secretary is the chief executive officer of the Veterans Health Administration, and that is the job which I expect to assume if confirmed.

You indicated some things about the size of the bureaucracy and the immensity of it. Let me try to respond to that by noting that health care, in my judgment, is primarily a local or, at most, a regional business, if you will. The decisions about the modes in which that care can be most optimally provided are generally best made on a local or regional basis. Indeed, that has been the experience of some of the larger private firms that have gotten into this. They have found

that you can't run it as a megacorporation from wherever Central Office happens to be; many decisions need to be made at the local level.

In addition to that experiential basis in health care management on a philosophical basis, I also believe that decisions are best made at the level with which they are going to have to be lived with and worked with. And so I would expect to have a form of management that is decentralized in the sense that local and regional personnel are going to have to manage their operations. I'll expect them to make decisions. There obviously needs to be some Central Office direction and strategy and vision, if you will, but one of my goals will be to try to make the decisionmaking as close to where those decisions are going to have to be lived with.

Chairman ROCKEFELLER. There is no question that the Secretary is the Secretary. He is the number one person. But when it comes to medical decisionmaking, you cannot run health care with a committee of three or four. It has got to be one person and it is going to have to be you if you're confirmed. And you fully understand that and want that?

Dr. KIZER. I understand the responsibility, and I also understand the challenges that go with it.

Chairman ROCKEFELLER. But that's the way you want to see it done? You yourself want to run that? You understand that there are two folks above you that you have to report to, but that you take this health care system and, working with the regional localities that you spoke of, that it is your responsibility to make it work?

Dr. KIZER. It is my understanding and expectation that the Secretary and Deputy Secretary will be holding me accountable for my actions, just like they will be holding the Under Secretary for Veterans Benefits responsible for his actions and what goes on in that side of the Department. And again, it is my expectation that I will have primary responsibility for running the Veterans Health Administration.

Chairman ROCKEFELLER. I just emphasize that because it is not an academic matter. It is something that you will be probably challenged on. VA traditionally is an agency which is, as I indicated, top down. They don't like to distribute responsibilities out to where I think responsibilities ought to be. So it is easier to talk about than to do it. So you are going to have to be fierce and tough and determined on that. And I read you to understand that you will be.

Dr. KIZER. Sir, I might add that I have had some experience in this regard in my former life in California; that is, in having to sometimes take positions that weren't entirely popular either with those that I served or with those above me.

Chairman ROCKEFELLER. OK. Feel free to interrupt any time.

Senator MURKOWSKI. I'll interrupt any time now.

Chairman ROCKEFELLER. Go ahead.

Senator MURKOWSKI. When you were director of the California Department of Health Service, who did you report to, Dr. Kizer?

Dr. KIZER. On paper, I reported to the Secretary of Health and Welfare. In California government, there is a health and welfare

agency somewhat analogous to Health and Human Services in the Federal Government.

Senator MURKOWSKI. Would that have been a position in the California Governor's cabinet?

Dr. KIZER. That is correct. And then obviously the next level was the Governor. The operational norm was that I dealt directly with the Governor's Office a lot, both because of the controversial nature and the sense of urgency of so many of the issues that I was responsible for and the Governor's Office interest in those. It was often easiest to deal directly with the Governor's Office, although certainly keeping the Secretary in the loop. There were several individuals in the Secretary position during my tenure.

Senator MURKOWSKI. What was your salary from the State of California in that position, and what will be your salary in the position of Under Secretary with VA?

Dr. KIZER. As best as I can recollect, the salary when I left that position was about $100,000 a year. It is my understanding that the salary as Under Secretary is around $168,000 with some additional components that may be factored in at the discretion of the Secretary.

Senator MURKOWSKI. And that would include special physician's remuneration?

Dr. KIZER. It is my understanding that there are some special allotments made for being a physician, for having board certification, for being board certified in more than one specialty, and some other things of that type.

Senator MURKOWSKI. When you have that figure, assuming that confirmation moves as we plan, I would appreciate the record indicating what your salary is.

[Written questions from Senator Murkowski to Mr. Kizer and the responses appear on page 158.]

Dr. KIZER. Certainly.

Senator MURKOWSKI. Why did you accept the President's request?

Dr. KIZER. Well, I see this as a wonderful opportunity to help some fellow veterans and also to move a system that I think can be a model for how government health care can be run. I see it as a wonderful opportunity to make government more responsive to the people that are served. It was a challenge that I couldn't refuse.

Senator MURKOWSKI. Obviously, moving up from the head of the California health services system to the Nation's largest health care system is certainly an increase in responsibility. It also, of course, affords, as the Chairman has mentioned, exposure to political realities associated with the input from the veterans organizations who have certain traditional objectives that they lobby for—pressure by the Secretary and the Deputy Secretary—to thread the needle between political pressures and your professional commitment to provide the very best care for our veterans. You are certainly going to have the task, I think, of being solidly behind a professional medical evaluation about what is in the best interests of veterans—as opposed to political expediency—regardless of what administration is in office. There is a certain amount of tension between professionalism and politics which you've observed in the California

system, I'm certain, and you will be exposed to even more, in my opinion, in the position which you are about to undertake.

There is no question, Dr. Kizer, as to your professional qualifications and your experience as an administrator. I guess what the Chairman and I are attempting to do in our own individual ways is to condition you a little bit to the rigors associated with the responsibility which you are undertaking.

I only have one question, and that involves changes within VA to meet the demand for outpatient services, as opposed to VA's more traditional commitment to inpatient care—as seen in its system of 171 hospitals. How do you go through a transition from an inpatient care system to an outpatient model when any effort to close a hospital is automatically attacked by the veterans organizations as a reduction in the health care capability of VA? I'm exaggerating a little bit, perhaps, but I have the flexibility of doing that from time to time. So, how do you bring about this change—if, indeed, you feel that outpatient care is a priority—while at the same time you might be faced with the reorganization within VA as it may go into a national health care system where it would have to be competitive? We have seen some statistics that suggest that VA may have a difficult time competing if, indeed, a veteran can go to a hospital of his choice. I wonder if you would just wander into that swamp a little bit, and that will conclude my questioning.

Dr. KIZER. Certainly. Thank you. First of all, let me note that I think the input from the veterans service organizations is very important, and I look forward to working with them. I am hopeful that there will be a very open dialog with them, as well as with this Committee and other interested parties on veterans health.

I think the veterans organizations and the Veterans Health Administration are interested in providing state-of-the-art care. Certainly, what we have seen in the private sector, and will increasingly be the norm in the future, is a shift in the paradigm of care to an outpatient or ambulatory basis. There are a number of technologies that are on the verge of becoming available that are going to even further accelerate that process. That will make the traditional general acute care hospital more of a dinosaur than it has already become in some cases. I think that as we work through this that it will become clear to the veterans service organizations, as well as other interested parties, that if we are going to provide state-of-the-art care to veterans, then the VHA is going to have to make some of these shifts. Whether this involves reconfiguring an institution or changing its mission or making some other adaptation, those are all logistical details that will have to be addressed on a case-by-case basis.

But the shift in paradigm and the manner in which health care will be delivered certainly in the private sector in the 21st century is going to be primarily towards an ambulatory-based system. We have to make that change. I think the facts of it, the advantages of it, and certainly the economics of it will become clear as we pursue this with individual circumstances and individual facilities in mind.

Chairman ROCKEFELLER. CALPERS obviously is one of the approaches to cost containment which has been very attractive to

many of us. It was very interesting in that CALPERS was running above budget for a number of years, and then there was a line item that was put in the California State budget several years ago that basically said this is the amount that can be spent on public employees for health care in California. All of a sudden, the bids came in lower, so to speak. In other words, aggressive bargaining, very aggressive bargaining has served California well, and California I believe in its last two budget cycles has even come in under what was budgeted. And that's a very good record and a very good lesson for us to look at here in Washington.

If you are confirmed, Dr. Kizer, do you foresee using that kind of approach to cost containment or other kinds of approaches to cost containment? In other words, being aggressive in negotiating for health care services. Not sacrificing on quality, but simply doing what I had to do when I was Governor of West Virginia and we wanted to build some roads and contractors would come in too high. We couldn't afford what they came in with—I'm talking about big roads—and we would say, sorry, come back with some lower bids. They always did. They always did and they would fit within the budget and we would build the roads. Now, this isn't the way we usually do things in Washington. I like what California has done on that. I like aggressive approaches to cost containment, and I suspect that Senator Murkowski does, too, because it saves taxpayers' dollars and doesn't have to cut quality. I would just be interested in some of your views about the California experience and how you translate that to what you might be looking at here.

Dr. KIZER. Let me respond in a number of ways, and let me preface it by saying that having worked in very fiscally constrained times in California under conservative administrations, I am very mindful of the budget and the need to come in under budget whenever possible. I would also note that some of the changes that you reference at the CALPERS system coincided with the new person coming on board there, one of my former subordinate managers in the Medi-Cal program, someone that I had recommended for the program and had endorsed to take that position.

There were a few strategic things that CALPERS has done. One of the most important things that they did was to specify a standard package of benefits that all plans had to bid on. One of the historical problems in that and other programs is that different carriers would come in with a different array of benefits and there was no way that you could do a cost comparison on an apples-to-apples basis. One of the fundamental efforts that Mr. Alcan and his staff pursued was that everyone had to bid on the same scope of benefits. Then you could get real price competition. Until that occurred, there was no way that you could actually have real competition.

The other strategy that is used, or one of the other strategies, was using the leverage of that system. That is a system that covers or is responsible for covering the health care of a very large number of individuals, and they have used to the maximum extent possible that leverage. That is a strategy which certainly the trade groups in California will acknowledge that I used very commonly with the Medi-Cal program. Indeed, one example of that that did get enacted

into Federal law was our Medicaid drug contracting program. As you may recall, I was engaged in a national debate with the pharmaceutical manufacturers group prior to that. We did get passage of that in California and subsequently it was enacted at the Federal level, basically using the leverage of the Medicaid program to get better prices on drugs that were purchased through that program. I think it is a fundamental strategy and certainly one that I intend to utilize if I am confirmed for this position. The VA does cover a lot of individuals and hopefully in the future will be providing services to more individuals because the system will be an attractive one that veterans will want to seek care at. And in that regard, we will have increasing leverage and I would expect to use that.

Senator MURKOWSKI. Mr. Chairman, if you will excuse me. I have got to go back to my office. I did want to ask unanimous consent that statements from Senator Thurmond and Senator Jeffords be allowed to be entered into the record. I understand that they are available now.

Chairman ROCKEFELLER. Without objection, they will be entered.

[The prepared statement of Senator Thurmond appears on page 128; the prepared statement of Senator Jeffords, on page 129.]

Senator MURKOWSKI. Please excuse me, Dr. Kizer. I wish you well. I am going to ask that the second part of my question—that is, how you envision VA competing if indeed we adopt at some point national health care legislation—be submitted for the record and that will give you a little more time to reflect on it. With that, I would ask that I be excused. Thank you very much.

Dr. KIZER. Thank you, Senator.

Senator MURKOWSKI. Good luck to you, Dr Kizer. Nice to meet your family.

Chairman ROCKEFELLER. Of course, when you're trying to lower cost, you're not just dealing with pharmaceuticals. I resonate very much with what you said because Henry Waxman and David Pryor and myself and John Chafee did just exactly what you all did with using Medicaid, which is, after all, the largest purchaser of pharmaceuticals in the country. So I thank you for that example. But we also deal with providers, we deal with academic health centers. You come more from an academic background to some extent, than had you been a career VA person. I am a very strong supporter of academic health centers and, in fact, my family has been for many, many years. I also understand that they are going to have to make some adjustments, one of which is they are going to have to start training more generalists and, in a ratio of some parity, generalists to specialists. In fact, under a proposal which is in one of the bills out there now, the number of specialists in real terms continues to go up. But specialists consider that to be an assault.

But there are a variety of adjustments that academic health centers are going to have to make, just as everything in health care is going to have to make adjustments. So I need to know that not having come up through VA, that you are willing to be tough on providers and academic health centers and others in the same way that you are on pharmaceuticals. I mean appropriately so—not inappropriately so, just appropriately so.

Dr. KIZER. No, I understand and I appreciate the opportunity to comment on that. I think, again, my experience in California where I did have to deal directly with the California hospital association, medical association, and a whole long list of other groups representing different sectors of the health care industry in addition to pharmaceuticals, I believe the reputation that I carried away from that was that I was a fair but tough person to bargain with and that most people went away feeling that the deals were hard won. So I think that I have a track record in that regard.

I can only say with regard to academic medical centers, I believe that they are having in many cases certainly as tough a time, if not a tougher time, than the Veterans Health Administration in recognizing and putting in place the realities of health care in the later 1990's and certainly in the 21st century. That is a system in tremendous tumult at this time. I think the potential for synergies and for the Veterans Administration and the academic medical centers to benefit each other has been well demonstrated in the past and will continue to be an area for synergistic relationships in the future. But I certainly would expect that in any accord that is reached in that regard, that it will be to the benefit of veterans and to the patients and individuals that are served by the Veterans Health Administration, and that we will maximize whatever leverage we may to get what is best and the most we can for veterans out of that.

Chairman ROCKEFELLER. Good. You mentioned in your statement you want to treat veterans with respect. That is not only something you should say but it is something that is very important that you did say. I share your concern about this. John Moseman, who is not here today, and Jim Gottlieb, who sits here, and I, when I can, we sally forth often unannounced into VA hospitals. The place I always go first, or it happens to be the place where it is natural to go first, is the waiting room. I think you can tell a world about a VA hospital by its waiting room. Some of them are terrific and some of them are just awful. I have been in some where you walk in and you feel like you are a thrown away piece of furniture. Everybody has got tenure there, they've all been there for a long time, there are not many smiles around. Veterans seem to have to wait longer for service in hospitals than do people in non-veterans hospitals. I suppose you could argue the reason for that is that other hospitals aren't constrained by the budgets that we are here at the Federal Government in our VA system.

But there are a variety of ways that one can reach out to the veteran in a health care system to try to make that veteran feel important, well served. One thing that occurs to me that we've started and will complete probably at the end of this year or next year—an amazingly simple idea—is simply that in any private hospital you go into, there is always a phone by the bed. If you go to a veterans hospital, there is never a phone by the bed. I contemplate myself as a veteran in a veterans hospital knowing that my child is sick and I can't call, except if some nurse brings a portable phone, which means she has to leave her nursing station and all of the complications from that. We are proceeding now to put telephones by

every single veteran's bed in the United States of America with the help of a lot of volunteers and some companies and the Federal Government itself. I am just trying to reach a little bit more beyond the waiting room to how do you make the veterans feel well served, well taken care of. I am not explaining it well, but you understand what I am saying?

Dr. KIZER. I think I understand what you are asking. I think the most simplistic but it is also perhaps the best way, is that we would treat them the way that we would want to be treated ourselves if we were a patient there. Actually, I smiled when you were giving the telephone example because about a year and a half, two years ago my wife happened to be in the hospital and I tried to call and the phone wasn't working. We went round and round and I called the ward nurse, the charge nurse, others, and they never were able to get a phone next to her bed that night that worked. I found it terribly frustrating because there were some things that needed to be communicated. So I appreciate that and I think that those are the sorts of things that can be done.

There is a whole host of things that could be done to reduce waiting times. I am not expert enough at the system and the peculiarities of different institutions to speak with any authority on that right now. But getting information up front before a person comes in, to minimize the amount of time that they have to spend in a line filling out forms if they're coming in for surgery or some other procedure, or having individuals that are targeted to specific sorts of information queries and doing that in advance as much as possible. I am not being very specific here, but I think we can look to what has happened in the private sector in many cases and ways that they have made the system much more patient sensitive and responsive so that the patient feels better about their health care encounter than might be the case in some of the VA facilities that you're referring to.

Chairman ROCKEFELLER. Anyway, that's very much on your mind, I have the feeling.

Dr. KIZER. It's the sort of thing that if we're going to compete in tomorrow's health care environment, we have to make it a very user friendly environment.

Chairman ROCKEFELLER. You can bet your bottom dollar on that.

Let's talk about research for a minute. You have been involved in a lot of research. We feel very strongly about research in the VA system. In fact, every year there is a kind of war because it gets cut by the executive branch and then we have to fight to restore it. But the kind of research that the VA system does is very different, for example, than what would be done in the normal academic health center or other places. I would like to get your views to the extent that you've looked—and if you haven't, then say so—but if you've looked at VA research, what you know about VA research, what your thoughts are about the importance of the VA research programs. It has a particular importance psychologically as well as literally in our whole health care system. Do you have any thoughts on that?

Dr. KIZER. I have some thoughts, and I would preface it by saying that I again feel a need to become much more familiar about some of the particular dynamics that are going on there before I can speak

with authority. It is, at this juncture anyway, my impression that the research program is, and has been, beneficial to VA. There are certainly problems that are unique to veterans that are not on the radar screen of the NIH or some of the other funding agencies and that needs to be a key element of the Veterans Health Administration. I also think that experience has demonstrated that there is a salutary effect on quality of care and our ability to attract top notch clinicians by having research opportunities available. Certainly, many of the type of individuals that we would like to have within any health care system are only going to come to a system that provides them the opportunity to do some investigative work, and that has a benefit that is far greater than their particular research project, per se. So overall, I think it is something that has a salutary effect and that is good, and it does address some of the particular and unique problems that are prevalent among veterans that are not well funded or necessarily the purview of other funding agencies.

Chairman ROCKEFELLER. A lot of that research spills over to non-veterans as well.

Dr. KIZER. Absolutely.

Chairman ROCKEFELLER. There is some really remarkable research going on.

Now, let's for the moment make the wildly improbable assertion that universal and comprehensive health care reform does not pass this year.

[Laughter.]

Dr. KIZER. I thought you had that taken care of.

Chairman ROCKEFELLER. Whether that does or does not occur, or to what degree it occurs, VA has to go through some major changes. Just to the extent that you care to, I would like to have some of your thoughts about what you think needs to go on in the VA system in the way of change, whether or not we have national health care reform.

Dr. KIZER. Frankly, I think many of the things that the Veterans Health Administration needs to be focusing on should be going forward regardless of national health care reform, whatever form that may ultimately take. Certainly, the notion that we've talked about earlier of having integrated networks of care that provide a seamless continuum of care, that is premised on a base of primary care with a very strong ambulatory component and long-term care component, and then special services that deal with some of the unique problems that are found among veterans, those things need to go forward regardless of what happens in the national health care reform debate. The economics are going to make it happen one way or the other.

I think there is a lot that we can do to facilitate that process, to ease the pain that any system experiences when it undergoes some fundamental reorientation in its mission and how it does its job. There may be indeed some things that particularly need to be done with regard to the Veterans Health Administration in the area of eligibility reform or allowing some pilot projects and innovative projects to be pursued that we would want to have some experiential base on before we advocated it as a national basis or shift the whole

system in one way or the other. I think that having that flexibility, a la, for example, the pilot States program, are some things that we may well need legislatively independent of the national health care reform legislation and how VA may be tied in with that.

Chairman ROCKEFELLER. Do you like to get into hospitals and wander around and look at wards and pop your head in rooms? You have got a lot of hospitals in the VA system and you will be new to it if you are confirmed. You will have enormous responsibilities here, enough to tie you to your desk for a very, very long time. But getting out there and meeting people and seeing what the real situation is, is not only incredibly important for an Under Secretary, I think, but it is extremely important to those who are visited in terms of morale and the sense of confidence which may not be there at the present time. So that if you are confirmed, and I expect you to be so, showing yourself, being out there, visiting, being hands on, that you're here and you're there—the word gets around that this guy named Kizer is really into his work and we better shape up because he knows what he's doing and he cares and he's likely to turn up tomorrow morning. You understand the attitude that I'm talking about.

Dr. KIZER. I think the only way you really find out what is going on in a system as large and as farflung as the Veterans Health Administration is to see the facilities, to perhaps present oneself unannounced on occasion or at unusual times or whatever, but to actually see the facilities, to learn firsthand about what's going on. There are a lot of filters that go between the field and a central office. Again, I have had some experience in this regard in the past and I often found that sometimes the most revealing briefing I had was a 5 or 10 minutes with a low level person in some out of the way place that really told me what was going on. That is often much more helpful than all of the white papers or other reviews and things that come across your desk.

Chairman ROCKEFELLER. I think it is very hard not to get encased by the people surrounding you, to break out. I think in a system this big, even somebody who really wants to do that can find it hard. But I think that I see in you that kind of determination. I think you are very right in that I have often found at various times in my public life the times that I have been most inspired have been the most unlikely situations, where you just happen to drop in at a particular situation but something was very real, somebody was just talking to you in ways that were so straight and so direct that it just made a powerful impact. But you have got to be out there to have that happen. And that would be your instinct, right?

Dr. KIZER. Absolutely. And clearly, one of the challenges in this job is how much time is spent here, how much time to spend with you all, how much time to spend in the field. That is probably why it is not an 8:00 to 5:00 job.

Chairman ROCKEFELLER. Yes. Right.

Please tick off, if you could, a couple of priorities that you see for your own sense of VA and its health care system.

Dr. KIZER. If I understand your question, I think I would go back to what I said before. What I would hope to see happen during my tenure would be a system that moves in the direction of a

decentralized system where real decisionmaking authority does occur in the field with appropriate accountability, that it does become truly an integrated system of care that provides care in a way and at a cost that the taxpayers would feel that their money is being well spent and that they would also feel like they would want to be taken care of at that facility.

Chairman ROCKEFELLER. The position that you have is overwhelmingly important. When I was lucky enough to become Chairman of this Committee, it was interesting because I myself am not a veteran, and I think it's probably the first time that there has been a Chairman of this Committee who is not a veteran. But the veterans service organizations weren't really upset about that because they knew, and know, that I have an abiding passion about health care. In fact, about 90 percent of the time that we spend on anything in this committee room is on health care. We have problems on benefit adjudication, all kinds of things, claims adjudication, but health care is so dominant, not just in the culture of the moment but just the nature of what it is that VA does.

So having an Under Secretary who is really good and is really committed and who sees this as something that he wants to get into and stay in and master the situation, shape the situation in a way which leaves a legacy is, I would say, as important, or maybe more important, than the Secretary himself. I think this is the job that you're applying for. It is a monumentally important job on the largest health care system in the United States of America. I assume that you have given a lot of thought to that because you have applied for the job and presumably there were a lot of other things that you could have done. But I just want to say that I look upon the job as very important.

You and I will be seeing a lot of each other if you are confirmed, which I expect you to be, and I will have very high expectations of you personally and professionally within the bureaucracy, the skill with which you handle committees, Congress, the politics of all of this, big "P" and little "p" politics. These things are often undervalued and misunderstood by people who come in from the outside, who come in from a more clinical setting. Now, you've been in State Government, so you understand something about that. But it is a very difficult system and yet it is a massively important one that just endless numbers of veterans depend on.

Let me ask you one final question, Dr. Kizer, and then we will leave it for the moment. You have had a lot of experience in the field of quality management. I wonder if you have had a chance to look at what VA does with respect to that?

Dr. KIZER. At this point, I have not had an opportunity to explore that. We've had some preliminary discussions about this. As you may know, I did pioneer a program in California State Government on quality improvement and did a number of things, and the Department actually won a number of awards with regard to continuous quality improvement and other efforts, and that did result in a statewide movement, if you will, subsequently. But I am committed to those concepts.

How I actually operationalize that is something that I need to see what is currently being done and make some judgment on the adequacy of that, or at least my assessment of the adequacy of that; what other things might be done; what other people might need to be utilized; what other training, skills, other things might need to be brought to play, because I think it has become clear in other quality health care organizations that you have to live and breath and eat and drink quality improvement all the time if you are really going to make that happen in a large organization. So at this time, I can't provide you with a definitive answer, but it is one that I will certainly be looking at in considerable detail if I am confirmed and ultimately assume the role.

Chairman ROCKEFELLER. Could you do something for me on that in particular; and that is, just in the period of the next 4 to 5 weeks, put down a few thoughts on paper informally and send them to me? You have got a lot of background in it.

Dr. KIZER. On how one might implement a quality improvement program?

Chairman ROCKEFELLER. Yes. Whatever thoughts you might have on that with respect to VA, taken from your previous experience. I would be very interested in that. It can be informal communications.

Dr. KIZER. Certainly. I will certainly get something to you, sir.

Chairman ROCKEFELLER. Good. Dr. Kizer, I don't have any further questions. I have already written you a lot of questions and you have answered a lot. I think you are going to find a very good reception in this Committee and will work well with the House, too.

The VA is an extraordinary asset. It boggles my mind as I sit hour after hour, week after week listening to the Senate and the House talk about health care reform, that Senator after Senator just leaves out the VA system, which is the biggest system in the country. It boggles my mind the way it is neglected. Part of the reason for that is because VA hasn't marketed itself, and it is something we're going to have to get good at in order to attract veterans if VA hospitals do become open for all 27 million veterans rather than just the 2.7 million veterans who now use them.

But it is a magnificent position that you are going into. I am glad you have applied. As I say, my expectations of you will be very, very high and I expect that you will meet them with very high standards. The expectations of the veterans of you will be very, very high because they are waiting for you, in constructive terms. They want results. They want health care and they deserve it, and that's what we all signed on for.

I don't have any further questions. I want to thank you and I want to thank your wife and two beautiful daughters for coming today. We will try and move this as quickly as possible.

Dr. KIZER. Senator, thank you very much for having me here and allowing me this opportunity. I certainly hope that I can live up to your expectations and the expectations of the veterans service organizations and the others who are interested in this. I also hope that, Heaven forbid, if 4 years from now we're still engaged in a national health care reform debate, people will not be leaving VA out of the discussion at that time.

Chairman ROCKEFELLER. Me too.

This hearing is adjourned.

[Whereupon, at 4:20 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX 1.—NOMINATION OF R. JOHN VOGEL

PREPARED STATEMENT OF CHAIRMAN JOHN D. ROCKEFELLER IV

Good morning. This hearing is to consider the nomination of R. John Vogel to be the Under Secretary for Benefits at the Department of Veterans Affairs. John, it is a great pleasure to welcome a fellow West Virginian. John appeared on behalf of VA at one of the first hearings I held as Chairman of this Committee. At that hearing, to my pleasant surprise, John noted that he is from West Virginia. This time around, I am enormously glad to be the one to note that fact.

I extend a warm welcome to you, as well as to your friends and colleagues who join you today. I thank you all for coming.

I congratulate you, John, on your nomination as Under Secretary for Benefits. You have a tremendous opportunity to share your vast experience in veterans programs, acquired through your many years of service to our Nation's veterans, as well as the wisdom and common sense of a West Virginian.

John Vogel clearly understands the special obligation we have to those who have served our Nation in the military. As a veteran of the Vietnam era and a distinguished, long time, career employee of VA, John has served this Nation and this country's veterans with honor and dignity.

After graduating from Wheeling College in his hometown, John served as a battery clerk and an artilleryman in the U.S. Army. Shortly after leaving the Army, John began his career with VA here in Washington D.C.

In over twenty-five years of VA service, John has been a veterans claims examiner, a legal consultant and an education specialist here in Washington, and an adjudication officer in the regional offices in Portland, Oregon, and Washington D.C. In 1979, he became Director of the Portland VA Regional Office, and he has also served as Director of the VA Regional Office in Philadelphia, as a Special Field Operations Representative in Baltimore and, most recently, as Director of the VA Medical Center in Bay Pines, Florida. John is in a unique position as nominee for Under Secretary for Benefits, having held the equivalent position of Chief Benefits Director in the Veterans Administration from 1985 to 1990. Among the many awards he has received throughout his career was the Secretary of Veterans Affairs Distinguished Service Award in 1990.

John, by nominating you to this position, President Clinton has shown great confidence in your work and appreciation for your commitment to veterans.

In closing, I note that John Vogel has completed the Committee Questionnaire for Presidential Nominees and responded to my prehearing questions, all of which will appear in the hearing record. Also included will be

a letter from the Office of Government Ethics acknowledging that he is in compliance with laws and regulations governing conflicts of interest. I have reviewed the FBI report on John Vogel and find no bar to his confirmation.

You are being considered for the position of Under Secretary for Benefits at a time when the Veterans Benefits Administration is truly at a crossroad. This job will bring with it significant challenges. You will be presented with an enormous opportunity to bring to bear a career's worth of experience in veterans programs in order to meet those challenges.

I look forward to hearing your testimony and to working with you as you seek to meet the challenges faced by VBA.

PREPARED STATEMENT OF SENATOR BOB GRAHAM

Mr. Chairman, I am pleased today to introduce John Vogel as the nominee for Under Secretary of Veterans Affairs for Benefits. would also like to take a moment to recognize the members of his family who are in attendance: His wife, Georgia, a recent graduate of St. Petersburg Junior College, and his three children, Raymond, Matthew, and Anne.

On January 5, I spent a day working at the Bay Pines VA Medical Center in Bay Pines, Florida, where Mr. Vogel served as Director from 1990 to 1993. During my visit, I was very impressed with both the professionalism of the staff and the positive remarks I heard from veterans about the quality of service. Many veterans commented on the feeling that Bay Pines is more than just a hospital. That it is a caring community which makes a genuine effort to reach out and understand the needs of its veterans. And that it shapes its services to meet those needs rather than following a rigid, institutional pattern of practice.

Mr. Vogel has a long and distinguished record at VA, including his tenure as Chief Benefits Director from 1985 to 1990. I am confident his vast experience within the VA health care system has more than adequately prepared him to serve as Under Secretary for Benefits.

I congratulate Mr. Vogel on his nomination and look forward to working with him in his new capacity.

PREPARED STATEMENT OF SENATOR DANIEL K. AKAKA

Thank you, Mr. Chairman. I wish to join you in welcoming John Vogel and his family to today's proceedings. Aloha, John. It is a real pleasure to welcome you back here again. You've testified before this Committee on many previous occasions, but this is probably one of the few times you're actually looking forward to the experience!

John, few individuals have ever been as prepared as you to undertake the responsibilities of Under Secretary for Benefits. I see three primary qualifications you bring to the job. First, as a disabled veteran yourself, you are sensitive to the problems of service-connected veterans. This is a necessary attribute in anyone who aspires to high office in the Department of Veterans Affairs.

Second your experience in veterans benefits matters is unmatched. Beginning in 1968, you've served as a claims examiner, adjudication officer, regional benefits director, and Deputy Under Secretary for Benefits today. Most important, of course, you've already held the job to which you've been nominated, although under a different title, when you served as the Chief Benefits Director in the last administration.

Finally, as a former hospital director, you have the unique advantage of having worked on both the health care and benefits sides of the Department. This experience gives you a special appreciation of the vital connection between health care and compensation programs. This appreciation will be critical in the years ahead, as VA enters the era of health care reform.

John, you have a big job ahead of you. In addressing old problems such as PTSD and Agent Orange, as well as new ones such as Persian Gulf War Syndrome and Radiation testing, you will be asked to chart a wise and prudent course in the benefits arena. And you will be asked to do so in an agency that suffers from budget constraints, excessive bureaucracy, and, all too often, a poor image among veterans. I, for one, believe you are up to this challenge. It goes without saying that I strongly support your nomination, and have little doubt that you will be confirmed. I look forward to continuing to work with you when you assume your new duties as Under Secretary for Benefits.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR FRANK H. MURKOWSKI

Mr. Chairman, this Committee, and the Senate as a whole, will face a number of critical issues during the coming year. Much of our attention will be directed toward health care issues, including where VA will "fit in" if reforms are enacted. Since we will focus so much on health care in the coming year, I am pleased that this hearing—coming as it does on the second day of the second session—affords both of us the opportunity to reaffirm that VA's benefits system will continue to be a prime topic of interest to this Committee in the coming year.

As you know, Mr. Chairman, the backlog of VA claims waiting to be processed has grown to unacceptable levels. By all appearances, that backlog will get worse before it gets better, growing over the next two years from over 550,000 cases to an astonishing 800,000 cases. The nominee before us this morning faces tough task of dealing with this overwhelming case backlog.

We know that VA faces more claims to process. We also know that the processing" of individual claims has become more complex and, in my opinion, "over-lawyered." We also know that VA will not likely be receiving any significant increases in staffing to deal with the backlog and that VA must, therefore, learn to do more with less. I am pleased that Mr. Vogel's prepared testimony appears to recognize that VA must change how it does its business—it must work smarter—if it is ever to get out of the case load hole in which it finds itself.

You're a brave man, Mr. Vogel, to take on this job. I think it is clear that, from your background at nearly every step of the adjudication process, you know and understand VA's benefits system thoroughly—perhaps better than any other person. We in the Congress will look to you for leadership. We will

also look to you for concrete suggestions on how legislation might assist you In getting control of the adjudication mess we must face together. Our constituents and your clients, this nation's veterans, deserve—and will accept—no less.

PREPARED STATEMENT OF SENATOR STROM THURMOND

Mr. Chairman, it is a pleasure to be here this morning. I join you and the members of the Veterans Affairs Committee in extending a warm ,welcome to the nominee, Mr. Vogel as well as to his family, friends and guests who may be accompanying him. I am pleased that the President has nominated a person of experience and ability for the important position of Under Secretary for Benefits.

Mr. Chairman, this nominee appears well qualified for the position to which he has been nominated. Mr. Vogel is a Veteran of the United States Army. He is a career employee of the Department of Veterans Affairs. As such, he understands the challenges facing the Veterans Benefits Administration as well as the resources which can be employed in meeting those challenges.

Mr. Chairman, as you are aware, the Veterans Benefit Administration must deal with a number of issues. A critical issue is the adjudication backlog. The number of claims for benefits pending in the system is growing and the processing time is increasing. This trend will likely continue as more Veterans enter the system. Other issues which must be addressed include reinventing government proposals and benefits reform. While there is a strong focus on VA health care reform, let me emphasize that other benefits programs consume over one-half of the Department's financial resources.

I congratulate the nominee on his willingness to serve his Nation in the position to which he has been nominated. He has the ability and the desire to serve. His experience within the Department has prepared him for success in this position.

Thank you Mr. Chairman. I look forward to reviewing the testimony of the nominee.

PREPARED STATEMENT OF R. JOHN VOGEL, NOMINEE TO BE UNDER SECRETARY FOR BENEFITS FOR THE DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and members of the Committee, I am honored to appear before you today and to be considered by you and this Committee for confirmation as Under Secretary for Benefits at the Department of Veterans Affairs.

As the old saying goes, "home is where the heart is." For me, home for many years in my public service vocation was the Veterans Benefits Administration. In that organization, I was a claims examiner, a senior claims examiner, a rating specialist, a program analyst, an Adjudication Officer, an Assistant Director, a Director, and a Chief Benefits Director. I saw good times and bad, but I loved the opportunity to serve and I loved the work itself, and always recognized its importance. There is no greater honor in public service

than to be entrusted with the opportunity to help American men and women who served in our military forces.

When I left the Veterans Benefits Administration, I felt that I was leaving home. I enjoyed my service as Director of a VA Medical Center and learned immensely during that assignment. But VBA is home. And home is where I want to serve now if you will support my nomination.

I come to VBA now with a real sense of the many challenges it is confronting. We have an almost unprecedented workload. Every operating division in our regional offices is struggling to get its mission accomplished. Adjudication, Veterans Services, Loan Guaranty, Vocational Rehabilitation. Each is trying mightily to maintain control of its work, to complete that work more quickly, to serve effectively and meet the expectations of our veteran customers and their families. Our resources are spread thin. We feel a sense of some crisis about our work right now.

And with that in mind, you must ask if John Vogel wants this job, and why, and whether he can do it well.

John Vogel does want this job! I want to tackle, together with our people, the job of turning VBA around—of making VBA a place about which the veterans we serve and the staff who provide the service can feel equal pride.

We must not deceive ourselves. In the excitement about tackling challenges, we still know there are far too many cases pending. The quality of our claims adjudication still requires major attention. Learning to communicate with our clients in a more simple, straightforward, helpful manner is an absolute necessity. We are too slow in resolving original and reopened disability claims. It takes far too long for a disabled veteran to begin the road toward vocational rehabilitation. We are really having difficulty keeping pace with our direct service and outreach obligations. Our need for automation advances to help us accomplish the work is acute and immediate.

And these, I recognize, are only a few of the things which the Veterans Benefits Administration generally, and its leaders specifically, must address now, and resolve.

But the picture I paint about VBA, the picture of VBA's future, is, I am convinced, a bright one. This is an organization staffed by a huge number of bright, dedicated, hard working and creative people. Our people want to do more and they want to do better. They are positioned to move to a new day. They understand what a "quality culture" is and they want that for VBA. They want to be contributors to our progress..

And, in the business sense, we are proud to have added over 100,000 new veterans to our compensation rolls during the past year. We have just reached the plateau that enabled us to guarantee the 14 millionth home loan. During the past year, over 300,000 active duty service members pending separation or retirement have received direct VA services. Nearly 400,000 have been helped with education and training benefits.

I am seeing our people, right now, running a huge campaign to assist persons with interest rate reduction on our homes. Our military services and outreach counselors are helping military members, here and abroad, to understand their benefits better than ever before—and to make sure they do not "leave the service without them." Everywhere I turn in VBA, our people at all

levels are producing new ideas about how to improve our organization and new ways to approach the management of our work. Together with them, we will find the right keys to open the right doors to a bright future.

Yes, I do want the job. And that is why I want the job. We have the right mission. We have the right people to accomplish the mission. And we are positioned now to demonstrate that we can become an excellent organization which serves veterans, their families and survivors with dignity, skill, accuracy and a personal touch.

The people of VBA have said emphatically that we need to concentrate in three important areas. I'll briefly enumerate them, but each seeks to move us closer to our customer—to meet their expectations and fulfill their needs.

We need, first, to complete our journey to "Modernization." Having the right tools to support expeditious claims processing and information services in all areas of VBA is an absolute necessity. Doing so as quickly and completely as we humanly can, and as quickly as resources allow, is what must be done. Good service to America's veterans requires tools, and those tools should be good ones.

Second, we must train. That realization has become very real in VBA. Throughout the organization, our staff is involved in technical, human relations and employee development training efforts that are making us better. But this is only the beginning. Our training endeavors must become much more extensive, much better organized and much more sophisticated. Veterans deserve public servants who understand completely every facet of their job and who, as a result, do it well at all times.

And third, we have begun to travel a path toward reengineering of our business process. We recognize clearly that we are products of our history and that many of our processes are no longer efficient or effective. How those processes should and can be changed, comprehensively, is the question. Our future depends on our ability to improve, to change in some small ways and in some large and dramatic ways. But significant change is not easy. There are many obstructions. There are many external customers to satisfy. There are budget implications in all we do. It is an immense challenge.

I want that challenge, for myself, and for VBA. This is a very exciting time for me. I seek the opportunity to serve as Under Secretary for Benefits, to "come home" to an organization I love, to work with its people and you.

Our veterans deserve our best. I will give it my very best.

STATEMENT OF RICHARD W. JOHNSON, EXECUTIVE DIRECTOR OF GOVERNMENT AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

The Non Commissioned Officers Association of the USA (NCOA) is both pleased and honored to submit this statement for the record in support of the confirmation of Mr. R. John Vogel as Under Secretary of Veterans Affairs for Benefits. Through many years of close association with Mr. Vogel, the 160,000 members of NCOA can attest to the superior personal qualities and many talents of the distinguished nominee that make him imminently qualified to be confirmed to the position for which nominated.

Mr. Vogel's singularly impressive career of exceptionally distinguished service to the Nation and veterans is a matter well known to this Committee. Lesser known to the Committee, perhaps, is the time and energy that Mr. Vogel has devoted directly to those organizations dedicated to serving veterans and, in particular, his long record of service and commitment to the members of NCOA. In his current capacity since February 1993 and previously, in positions at the national and regional levels of the Veterans Administration, Mr. Vogel has been steadfast in his devotion to NCOA, its members, and all veterans.

It is on the basis of the long-term relationship between NCOA and the nominee that the Association urges the Committee to unanimously support Mr. Vogel's appointment. His professional accomplishments, in positions of significant trust and responsibility, are indeed remarkable. More notable, in the opinion of NCOA, is the respect, esteem, and high regard with which Mr. Vogel is held among veterans. He is renown for is dedication, service and commitment. Mr. Vogel is attuned to the special needs of veterans. Among veterans, he is considered to be an individual of principled character, unwavering values and unquestionable integrity. Equally important, Mr. Vogel knows intimately the sacrifices associated with the privilege of serving in the Armed Forces of the United States. Simply put, he is a veterans veteran.

For more than 25 years, the nominee has dedicated himself to the Nation and its veterans; however, endorsement of his appointment is not merely grateful recognition of his past service. Mr. Vogel is imminently qualified to serve as Under Secretary for Benefits and, endorsement of his appointment is done with enthusiastic anticipation that he will again serve veterans with great success. Indeed, Mr. R. John Vogel is the right choice for the right position at a critical juncture in the future for veterans.

NCOA wholeheartedly endorses his unanimous confirmation.

WRITTEN PREHEARING QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. VOGEL AND THE RESPONSES

Question 1. What is your concept of the nature and extent of the Federal Government's obligations to the Nation's veterans and their dependents and survivors?

Response. The Nation has a solemn obligation to care for those who served in its Armed Forces. A number of veterans will not need our benefits, medical or non-medical, but we must stand ready for them and care for those that need our help. One cannot reflect on the collapse of the Soviet Union or think about the current bellicose position of North Korea, and not acknowledge the sacrifices of a steadfast Armed Force which contributed so much to the fall of the Iron Curtain. The benefits a grateful Nation provides its veterans help fulfill a moral obligation and also represent a good investment in a Nation that has citizen soldiers, sailors, airmen, marines and coast guardsmen in our country's uniforms.

Question 2. Section 306 of title 38, United States Code, requires that the Under Secretary for Benefits be appointed "solely on the basis of demonstrated ability in fiscal management and the administration of programs within the Veterans Benefits Administration or programs of similar content and scope."

Please describe the specific experiences you have had that you believe satisfy these requirements.

Response. Starting with a claims examiner position, I then assumed increasingly more responsible positions within VA, including Adjudication Officer, Director of a Regional Office, Director of the Regional Office and Insurance Center in Philadelphia, and Chief Benefits Director. I have also been Director of the Bay Pines Medical Center and, for the past 11 months, have served as Deputy Under Secretary for Benefits.

Question 3. What new experiences did you gain in your two-and-a-half years as Director of the Bay Pines, Florida, VA Medical Center, that you feel add to your capabilities to serve as Under Secretary for Benefits?

Response. I gained a full understanding of the operations of the Veterans Health Administration, saw first hand the quality of medical care provided our veterans and now know much of many opportunities for collaboration between VBA and VHA. There are abundant opportunities for data sharing for improved administrative management, all of which will allow VA to better serve our customers.

Question 4. Please describe in detail any conversations which, in connection with your selection for the position of Under Secretary for Benefits, you have had with any official of the Department of Veterans Affairs, OMB, or the White House about your political affiliation, political qualifications, or political activity.

Response. I have had no conversations with the White House, OMB or with VA leadership about partisan matters.

Question 5. Concerns have been raised about your role in the VA's actions in connection with the National Association of Radiation Survivors v. Turnage litigation because, as the Chief Benefits Director at the time, you were in a supervisory role over VA officials the Court found had destroyed potentially discoverable documents and otherwise failed to cooperate in the discovery process. Please comment on your role in VA's actions and on these concerns.

Response. I think I should first note the findings of the General Accounting Office. GAO looked in great depth at the entire situation—at the allegations, at the handling of documents, at the actions of VA staff. Ultimately, GAO concluded there was no evidence of the deliberate destruction of documents. Their detailed review found mistakes but not an intent to do wrong.

Second, let me relate to that time and the circumstances which swirled around us. It was a contentious time for some of the people involved.

I asked the Deputy Chief Benefits Director for Program Management at the time personally to oversee our responses to all discovery requests. All records were placed under special control. We cooperated fully with the Department of Justice and the courts, and endeavored to be fully responsive to appellants to the extent required by law. When allegations of inappropriate action or mishandling arose, I asked the Inspector General to intervene, review and make determinations.

My intention, from the early days of allegations about records and people, and throughout the litigation, was to try to do the following: secure and protect any records at issue; be fully responsive, personally and organizationally, to the

courts and the appellants; protect the interests and due process rights of all parties; and assure appropriate, compassionate and accurate handling of claims.

This was my obligation as Chief Benefits Director and it was the right thing to do in a business sense. We have tried to build on the lessons of that experience. Our intention is to assure absolute integrity in the claims process.

Question 6. Please outline your overall long range plans for managing VBA's workforce, including how you plan to administer and oversee total quality management.

Response. It is clear that our work has become more complex. My plan for the workforce is to increase the number of decisionmakers in all program areas. There will be a decrease in clerical personnel. I was a charter member of the Board of Directors of the Federal Quality Institute and have long been a proponent and practitioner of total quality management, both in VBA and VHA. We are seizing upon the creativity of our workforce, both in management and in those who directly provide service to our veterans. We are seeing positive results, both qualitatively and quantitatively.

Specifically, our long range plans focus on training, reengineering and modernization. We will simplify our business processes, develop our employees through a comprehensive training program and empower them to become decision makers by giving them the necessary tools and technology. Total quality management will be guided by our customers. We will listen to them and will develop quality business practices to satisfy their concerns, not ours.

Question 7. Do you have any plans for reorganizing VBA, either in VA Central Office or in the field?

Response. I will reorganize only to the extent that it improves the efficiency of the important work we do. My general goal is to have more people involved in direct service to our public. Some reorganization may be necessary as we proceed with our reengineering efforts and implementation of the recommendations of the Blue Ribbon Panel.

Question 8A. Vice President Gore's National Performance Review sets forth four key principles as the basis for "reinventing Government": (1) cutting red tape; (2) putting customers first; (3) empowering employees to get results; and (4) cutting back to basics. What is your general view of these principles as a framework for reinventing government as they apply to VBA?

Response. VBA's planning process focuses on three activities—Modernization, Reengineering and Training—that mesh well with the principles of the National Performance Review. Our Blue Ribbon Panel on Claims Processing put veterans first, most significantly by the active participation of the Veterans Services Organizations. Many of the recommendations of the panel will streamline claims processing, such as redesigning the form for disability claims, which will also benefit our customers. First-line supervisors were empowered as part of the panel, and the deliberations and recommendations "cut back to basics." Many of the same principles are inherent in other activities currently underway, such as individual pilot programs.

Question 8B. Please provide your assessment of the specific National Performance Review recommendations relating to VBA.

Response. I believe the five National Performance Review recommendations are consistent with our three focus activities: Modernization, Reengineering, and Training. We are now pursuing the means to accomplish each recommendation. For example, the DoD/VA Non-Medical Benefits Task Force established a joint working group of DoD/VA personnel to investigate and analyze the issues surrounding consolidating the two Departments' disability payment systems. The other recommendations are receiving similar attention.

Question 9. Do you plan to appoint any top Central Office managers from outside VBA's career force?

Response. I plan to appoint the most qualified people, and it is my hope that these would be from the VA career force.

Question 10. Do you plan to appoint any regional office directors from outside VBA's career force?

Response. My plans are to appoint the most qualified people, and it is my hope they will be from VA's career force.

Question 11. Do you support major Central Office program directors having their own advisory committees of field managers?

Response. Yes.

Question 12. It is a reality of life that program heads such as the Under Secretary for Benefits, in charge of administering billions of dollars of benefits to millions of veterans, will receive pressure from both outside and inside the Department to approve or to take a course of action that is "budget driven" which may not be in the best interest of program integrity or program beneficiaries. If confirmed as Under Secretary for Benefits and if subjected to such pressure, how would you respond?

Response. I will do the right thing by America's veterans. Our programs are time tested and are acknowledged to be effective. I will resist pressure to make budgetary and program decisions which may not be best for our veterans. I will enjoy the unqualified backing of Secretary Brown in advocacy for our veterans.

Question 14. Please describe your view on the priority EEO efforts should be afforded within VBA and what steps you would take to monitor regional offices' EEO practices and to encourage equal employment opportunity throughout the VBA.

Response. We cannot do the important work we do if we fail to take full advantage of the talents of a diverse workforce. Any actions which distract or detract us from our work, especially the destructive effect of depriving our personnel of their equal employment opportunity rights, will not be tolerated. It is expected that management embrace EEO and that performance is monitored.

Question 15A. Please describe the training and education in EEO matters that regional directors receive.

Response. The prevention of sexual harassment, VA's goals for equal employment opportunity, affirmative employment programs and discrimination complaint processing are agenda items at the annual conference of Regional Office directors. VBA people, the Office of Equal Opportunity, and the General

Counsel have discussed the laws and regulations on these matters at the Conferences.

VBA's Personnel Assistance Staff regularly distributes to regional offices a variety of literature on new developments in EEO and related matters.

Everyone in VBA had four hours of training on the prevention of sexual harassment, as directed by the Secretary. We'll also have refresher training each year.

Question 15B. Do you believe that such training and education is sufficient and, if not, what steps would you take to improve it in this regard?

Response. I believe the training field station directors receive, combined with our continuing emphasis on the importance of these matters, is sufficient. Human Resources Officers (Personnel Officers) and District Counsel attorneys keep the Director apprised of all of the laws and Regional Office Directors consult with them on all personnel related matters. If a station has problems, such as a higher number of discrimination complaints than may be expected, then we schedule that office's management for more indepth training. It's important to recognize that our day-to-day operations consider employee morale, career development, training, awards or other forms of recognition, performance ratings and the like. Routine attention to matters such as these goes a long way toward preventing personnel complaints and dissatisfaction.

Question 16A. I understand that the VBA Personnel Assistance Staff has conducted investigations of several sexual harassment complaints, some of which involved high level VBA officials. What has been the disposition of these cases—specifically, have they gone to court or been settled and have any of these officials been removed?

Response. Our Personnel Assistance Staff did an onsite administrative review of allegations of sexual harassment at a VBA field station. The allegations were not supported by the information gathered onsite, but we recommended to management that supervisor-subordinate communications be improved, that more career development opportunities for support personnel be offered and that on-the-job fraternization be discouraged. The Director accepted our recommendations and took immediate action on them.

EEO investigators substantiated one sexual harassment complaint. The Director of that regional office retired. Another investigation is in progress. There has been no court action on these matters.

Question 16B. What, if any, actions would you take as Under Secretary for Benefits to improve the awareness of VBA personnel on issues related to sexual harassment?

Response. The prevention of sexual harassment is now part of our daily environment, and attention to it is foremost in just about all of our daily operations. We stress, we caution, we alert, we remind all employees about it. I'm convinced that, after the training, all of us clearly recognize what constitutes sexual harassment. I'm also convinced that anyone who has worked for me knows that unacceptable behavior, especially that which devalues our fine workforce, just won't be tolerated. Added to this daily attention will be refresher training and I'll encourage all my managers to participate in any other training opportunities available.

Question 17A. What is your general philosophy regarding the use of decentralized pilot programs and test stations for research and development purposes? To the extent you have used such approaches, please cite some relevant examples and your evaluation of their effectiveness.

Response. Decentralized pilot programs are being used extensively and effectively to address the field stations' most immediate workload concerns and to find ways to better serve our customers. Field stations identify and test potential solutions to their most pressing problems in a real work environment, where results can be measured against prior achievements or other regional offices. Examples include various initiatives to reengineer work processes by combining Veterans Benefits Counselor/Veterans Claims Examiner functions and forming self-directed work teams and service delivery centers; creation of rating technician positions; development of the CD-ROM retrieval system for rapid access to needed reference materials; use of voice-recognition technology in VBA's work processing environment; automation of loan service and claims and property management functions; initiatives to improve letter writing; and supervisory, career development, and leadership training programs. Preliminary results indicate that these are viable initiatives with potential for improving both quality and timeliness and providing more personalized service.

Question 17B. Please describe VBA's ongoing efforts to coordinate, monitor, and oversee all of the pilot programs at regional offices and any changes you would make in this process.

Response. VBA monitors these pilot programs in a variety of ways including quarterly Management Council meetings with the area directors; updates to the Program Operating Plan and other strategic and tactical planning documents; periodic status reports by the testing stations; and VBA meetings with all key area and Central Office management staff.

Question 17C. Please describe the pilot programs currently being conducted at regional offices.

Response. The following provides brief descriptions of some of the pilot projects currently being tested.

Reengineering Work Processes: Self-directed work teams or service delivery centers are in various stages of planning and testing at our regional offices in New York, Muskogee, Jackson, Oakland, Portland, and Salt Lake. These offices are moving from a control-based to an information-based organization with more decisionmakers and with goals of improved timeliness and improved quality. The use of self-directed teams reduces the number of discrete jobs, with considerable overlap of job knowledge and function. Teams function independently and require only limited supervision. Philadelphia, Pittsburgh, Cleveland, Des Moines, Lincoln, Ft. Harrison, Phoenix, Anchorage, and Honolulu are also experimenting with the case management approach, combining various VCE and VBC functions. Initial results of these tests are encouraging.

Rating Technician Positions: A number of regional offices are working to strengthen and streamline the rating process by establishing paratechnical rating specialists or rating assistance technicians. These technicians are responsible for complete development and screening of cases requiring rating action and, in some cases, for rating less complex issues. Indianapolis, Waco, New Orleans,

Philadelphia, Oakland, Winston-Salem, and San Juan are among the stations testing this concept.

CD-ROM Retrieval System: The Little Rock Regional Office is pilot testing a project to determine the feasibility of CD-ROM technology to access VBA reference materials. VBA policy and directives, regulations, General Counsel advisories, and COVA decisions will be cross-indexed and stored online for rapid retrieval.

Voice-Recognition Technology: The New Orleans Regional Office is testing a prototype voice-recognition system for application to VBA work processes. This technology identifies spoken words and treats those words as computer input. While many applications can be envisioned for this system, the regional office has chosen the creation of rating documents as the initial test area.

Automation of Loan Guaranty Functions: A local area network is used in the New Orleans loan guaranty division to automate Loan Service and Claims and Property Management functions. The system eliminates

Question 17D. What is VBA doing, if anything, to encourage regional offices to take innovative actions to provide quality decisionmaking in a timely manner?

Response. VBA has placed great emphasis and expended significant resources on development of Total Quality Management programs at the regional offices. Quality improvement programs encourage employees to develop innovative and effective solutions to local problems and to make quality in daily work a way of life. Our strategic planning process also encourages innovation, collaboration among regional offices, and team decisionmaking. As a result of our TQM programs, employees have developed additional problem resolution skills that have enhanced their decisionmaking abilities. The culture of the organization has shifted to a focus on quality and timely service to our customers, with genuine concern evidenced for both internal and external customers. Focus groups and customer surveys are utilized to determine strengths and weaknesses and to identify areas for improvement, and a proactive approach to problem solving is encouraged at all levels

Question 18. Please describe your vision of the future organization of regional offices. Include your views on the potential consolidation or merger of the processing functions of several regional offices (such as the consolidation of the loan guaranty responsibilities in the New England states or of the adjudication of education claims at five regional offices), as well as any experience you have had with this issue. Describe the pros and cons involved in consolidation.

Response. There are instances when centralization is very successful. Persian Gulf claims are an example. When the situation dictated the need for highly specialized expertise to work claims timely and accurately, and to gather information, the Louisville RO centralization was the perfect answer. In other areas, consolidation is not feasible, such as centralizing all claims processing. Here, there's a need to be "close to home," so I would not favor consolidation. I will closely watch for opportunities that may result from intraoffice consolidation, such as the New York pilot project. If such a concept proves best, then we would go for it.

Question 19. To what extent has FTEE been reduced as the result of the consolidation of the home loan guaranty claims processing in New England?

Response. Initially, staffing at the consolidated site was less than the total of the four combined stations, but it has been increased because of the increased Loan Guaranty activity in the New England area. Low interest rates and the area's economy have sparked the home buying and refinancing business, so we've added extra people. It's still less than would be necessary if four stations had to be staffed. The chance of delayed processing is significantly lower because the "one-man expert" concept prevalent in small stations is gone. We can now process specially adapted housing loans out of Manchester, when previously these had to be done at Central Office because it wasn't feasible to have an expert at each of the small offices. We conducted followup evaluation last year and there's no doubt that this consolidation has been successful.

Question 20. In your view, are the four area directors effective in managing regional offices, and do you have any plans to change this organizational structure?

Response. The effectiveness of the current area structure looks sound, and I have no immediate plans to revise it. But I do plan to closely study the organization and, if necessary or better, I'll make changes.

Question 21. What is your view of the value of colocation of VA regional offices and VA medical centers?

Response. When there are deficiencies at the regional office, when cost considerations are favorable, when land is available, and if the new location is easily accessible and good for veterans, then colocation is valuable.

Question 22. As everyone is painfully aware, there is a tremendous, growing backlog of claims at VA regional offices. On a number of occasions, you have attributed this backlog to the advent of judicial review and the obligations placed on VA by the decisions of the U.S. Court of Veterans Appeals. Please describe in detail your view of the impact of the Court on the VA adjudication process. In your response, please specifically address the Court's holding on the following issues—which have been the subject of numerous significant decisions of the Court—and the impact they have had and will have on the claims process (including their impact on the quality of decisionmaking): (A) VA's duty to assist in the development of the claim; (B) the doctrine of reasonable doubt; and (C) VA's duty to provide adequate reasons or bases for its decisions.

Response. The Court has held that we must articulate the reasons for our decisions, so it takes more time to address all issues thoroughly, whether expressly claimed or inferred. That means individually composed letters instead of computer-generated notices of denial. It takes 25-50 percent longer to prepare a decision. In 1989, a rating specialist completed an average of about 8 cases per day. Now, it's 5 to 6 cases. Our decisions are now longer, but they are also more carefully worded, all issues are addressed, and they are more understandable. We are doing more to develop a claim. That adds to the time.

As for the reasonable doubt doctrine, we've used this principle all along. When the evidence is balanced, a determination in favor of the claimant is made.

To assure that we comply with the Court's decisions, we do more training. Regional Offices tell us that 10-15 percent more time is spent training rating specialists.

Our workload is higher, too, because of the impact of the Court's actions. Before its advent, the Board of Veterans Appeals remanded 18-20 percent of the cases back to the Regional Offices. In FY 1992, the remand rate reached 51 percent, but was down to 45 percent in FY 1993.

The Court's actions have a trickle-down effect, as well. We now need to look at thousands of other cases in various stages of processing that may be affected.

Question 23. How would you describe the Court of Veterans Appeals' relationship with VA and the current attitude within VBA toward the fundamental changes in the adjudication system mandated by the Court?

Response. I think VA has a good relationship with the Court. I participated in the Court's second Judicial Review Conference in October 1993, and was privileged to take part. I am pleased with the interaction of the Court, VA's General Counsel, the Board of Veterans Appeals, Veterans Benefits Administration, and the private sector. The impact of the Court has been tremendous, but it is beneficial to our clients, and for that, I welcome it.

Question 24A. Please describe VA's efforts to date in the communication to adjudicators in the regional offices of the decisions of the Court and instructions with respect to their practical effect on claims processing.

Response. We now have a Judicial Review Staff in our Compensation and Pension Service that reviews all Court decisions, remands and orders. They prepare a Decision Assessment Document on each case that outlines the changes or clarification of policy, rules or procedures that have become necessary. Recommendations are tracked to be sure they are implemented. Copies of the Decision Assessment Documents are sent to all Regional Offices.

When changes to the way claims are adjudicated are needed immediately, the Director of Compensation and Pension issues interim instructions electronically. These supersede other guidelines.

We conduct monthly Judicial Review Conference Calls, following up with transcripts that include the questions and answers cited during the call.

All of this is reinforced through regular training sessions, workshops, a national conference, and during station visits.

Question 24B. Do you have any plans for changing this communication?

Response. The basics of what we are doing will be changed by expanding or enhancing the process. We'll be more sophisticated. An automated manuals prototype, if successful, will mean that all VA directives, including the Decision Assessment Documents, will be available to users instantaneously, with rapid access to specific references. We're also looking at video teleconferencing and video tapes as extra measures of communication.

Question 24C. What measures is VBA currently taking to ensure that the regional offices are uniformly applying the decisions of the court?

Response. All of the information about Court decisions has been incorporated into our training courses. Last year, this covered new adjudication

supervisors and five classes of new rating specialists, or 218 people, representing every regional office. The Compensation and Pension Service also conducted 14 one-day Seminars on court matters at various locations, with 43 Regional Offices receiving this specialized training.

The Compensation and Pension quality assurance program assures that all Court-related directives are followed in its annual review of a representative sample of each station's cases.

We conduct surveys at about 25 stations a year, where we review with the Adjudication Divisions their understanding and compliance with the procedures, especially the newer ones arising from Court decisions.

Question 25A. What is VBA currently doing to ensure that claims are properly developed at the regional office and that all pertinent laws, regulations, and precedent decisions of the Court are considered and applied?

Response. We first try to assure that claims are properly developed by training the proper procedures. Then, we review the work regularly under the Quality Assurance Program, which covers three critical areas: timely control and proper development; the propriety of the decision; the completeness and clarity of the notification. Each adjudication division also reviews itself monthly in the same three areas.

Question 25B. As Under Secretary for Benefits, would you implement any new procedures or policies to help ensure a greater level of adequate case development and application of all relevant law in claims adjudication?

Response. A new system we are developing will be rule-based. It will tell adjudicators what evidence is needed. It will generate the requests for evidence. Piecemeal development will be eliminated. A new automated reference system will give claims processors current laws, regulations, procedures, court decisions, and legislation instantaneously. New word processing and data base technology will produce rating decisions. These changes aren't futuristic. We're working on them right now, and they will help.

Question 26. In light of judicial review, what actions might VBA take to protect the informal and nonadversarial nature of the VA claims process from becoming adversarial and legalistic?

Response. Judicial review has made the adjudication process somewhat more adversarial and legalistic only after the appellate process has begun. This has been unavoidable. We still continue to advocate the ex parte relationship we've maintained with our clients. We will be guided by our duty to assist in claims development. The hearing process has not changed.

Question 27. Is VBA taking any action to review its regulations, policies and procedures, given some of the Court's holdings in cases such as Fugere v. Derwinski and Gardner v. Brown?

Response. Review of our regulations and directives is a never ending process, and we get the word out on changes to procedures just as soon as possible.

The Decision Assessment Documents prepared on each Court decision alert field stations to what needs to be changed, and we quickly adapt it to formal form—manuals, regulations, or whatever is needed. In the last two years, we

identified 52 manual changes, 16 regulation revisions, and 24 other changes to be made via circulars or interim letters.

The monthly teleconferences discuss decisions. All of the Court-related information is updated regularly and quickly.

A Compensation and Pension task force is currently looking at the whole adjudication manual to see if there are any procedures that might not be supported by law or regulation.

Question 28A. What was the average number of days for processing an original compensation and pension claim for fiscal years 1990 through 1993, and what does VBA estimate that it will be for fiscal years 1994 and 1995?

Response. The average number of days for processing an original compensation and original pension claim for fiscal years 1990 through 1993 are as follows:

	Original Compensation	Original Pension
FY 1990	151	97
FY 1991	164	107
FY 1992	164	115
FY 1993	189	119
FY 1994	226	128
FY 1995	235	133

These are cumulative figures and represent the average of each of the twelve months in each fiscal year.

The estimates for FY 1994 and 1995 are based upon the actual figures for the past three years and the trends they indicate. We do not yet know with certainty the positive impact of the modernization technology and the action plan of the Blue Ribbon Panel—much of which will not be felt until the latter part of 1994 and 1995—so these estimates are based upon the figures we currently see and can expect.

Question 28B. How does this average processing time compare to the time it takes to process other types of claims, such as education, vocational rehabilitation, or home loan guaranty claims?

Response. It's hard to compare processing times between such widely varied benefits. What's needed to award a pension claim versus a claim for Montgomery G.I. Bill benefits is very different, as are the procedures. A Loan Guaranty "claim" could be from a lender claiming reimbursement, versus a veteran seeking a home loan. A Loan Guaranty certificate of eligibility can be issued on-the-spot. With a compensation claim, a lot of evidence is needed and most of it requires waiting, e.g., service medical records, private treatment records, verification of income. These waiting periods are, for the most part, not within our control.

In FY 1993, the average time for an original Chapter 30 education claim was 21 days; for a vocational rehabilitation claim, it was 71 days.

Question 29A. What is the average percentage of cases across the system that have been pending in regional offices for more than 180 days?

Response. As of November 30, 1993, 570,702 compensation and pension claims were pending decisions. Of those, 147,762, or over 25 percent, were pending over 180 days. If we exclude pending agent orange claims and appeals, for which processing timeliness is not totally under our control, we had 478,084 compensation and pension claims pending and 86,239, or just over 18 percent, were pending over 180 days.

Question 29B. Which regional office has the largest percentage of cases that have been pending for more than 180 days? The smallest percentage?

Response. Los Angeles has the highest percentage of cases pending over 180 days (excluding Agent Orange and appeals) at 43%. Des Moines has 3%, the lowest.

Question 29C. In general, is the trend of cases pending for more than 180 days increasing or decreasing across the system?

Response. Caseload went from 30,000 as of September 30, 1991 to 147,000 as of November 30, 1993; the trend is increasing. We think this will continue for at least the next six months because of remands from BVA and claims based on herbicide exposure, both pending and expected. In addition, DoD expects some 300,000 separations in FY 1994 and 295,000 in FY 1995. This downsizing will continue to lead to a high number of original claims, many of which will be complex and contain a multiplicity of issues. These types of claims tend to require more time to process and may add to the number of cases pending over 180 days.

Question 30A. Please state the maximum claims processing workload, timeliness, and quality you would consider acceptable for VA compensation and pension claims.

Response. We would consider a pending workload of 260,000 compensation and pension claims to be acceptable. With that number of pending claims, we would expect the timeliness for a compensation claim to be 106 days and for a pension claim, 77 days. The success level of quality for claims processing is measured in three key areas: control and development, propriety of decisions, and notification of the decision to the claimant. The goal for quality established in each area is 97 percent.

Question 30B. What funding levels and FTEE levels would be necessary to achieve these goals?

Response. If we were to give the existing backlog the most timely infusion of resources, we calculate that we would need staffing of approximately 6,000 fully trained adjudicative personnel for fiscal year 1995. With that level of trained staffing, the backlog would be reduced to the 260,000 case level by the end of FY 1995.

Question 30C. If the current FTEE levels remain the same, what predictions would you make concerning the adjudication system in the next few years?

Response. Currently our FTEE levels are about 4,500. If these levels remain the same, we estimate that by the end of this fiscal year the backlog of pending compensation and pension claims will increase from the current level of approximately 570,000 cases to approximately 712,000 cases and in FY 1995 to as much as 870,000 plus cases. These figures, however, do not take into account the impact of modernization and the Blue Ribbon Panel's

recommendations and action plan. We still must test and measure implementation of these initiatives before we can fully assess the overall impact.

Question 31A. Various VBA reports refer to "claims," "claims actions," and "cases." Please explain the difference between a "case," a "claim," and a "claims action."

Response. Generally, these terms are used interchangeably. However, strictly speaking, only the term "claim" is defined by statute and regulation and is used to identify or classify a formal or informal application for benefits.

The term "case" has been used traditionally to indicate a veteran's record (whether a claims folder or an electronic file) that requires work of some type. The work in a particular "case" will often emanate from a "claim" filed by the veteran or a survivor, for example. And, the term "claims action" is frequently used to describe a particular phase or stage in the adjudicative process, such as a development action or a rating action.

Question 31B. VBA annually reports how many "cases" not "issues" are appealed, but does VBA also have data reflecting how many claimed issues, involved in the claims actions reported, are denials of the benefit sought?

Response. Over the past few years the number of issues raised in a claim has increased. An original compensation claim, for example, might involve eight or more disabilities, each representing a separate issue requiring a distinct decision. We treat that claim as a single entity because it provides better customer service. The whole claim, not an individual issue, is the veteran's concern. As a consequence, we have no reports identifying individual issues in a claim.

Question 32. The VA Inspector General (IG) issued a report in June 1993 (Timeliness of Benefits Claims Processing Department of Veterans Affairs Regional Office Pittsburgh, Pennsylvania (3R6-B99-1 21, June 4,1993) on delays in claims processing at the Pittsburgh regional office. This report highlighted a number of significant deficiencies in the system.

(A) Are the problems found by the Inspector General at the Pittsburgh regional office typical or unique to that station and, if the situation is not unique, to what extent do other regional offices have similar problems?

(B) What prevented local regional office or VA Central Office management from taking action prior to the June 1993 report, along the lines of the actions recommended by the Inspector General?

(C) Have the changes been implemented in Pittsburgh based on the Inspector General's report and, if so, have they resulted in improved timeliness and quality?

Response. Some of the problems in the Pittsburgh Regional Office were attributable to data inaccuracies in the WIPP system, so that management's ability to monitor claims was affected.

The timeliness problem at Pittsburgh is not unique. Offices throughout the country have been experiencing much of the same situation, varying only in degree.

Both the Regional Office and Central Office recognized the deterioration in timeliness as early as March of 1992, when VBA did a site visit. They asked for a special analysis of causes for each affected end product, and followed up with a special help visit in December 1992. An improvement plan was prepared which led to better timeliness of 12 of the 13 end products. The workload dropped by 2000 cases between October 1992 and September 1993. The favorable trend prevailed during the early part of FY 94—8,650 cases were pending at the end of November, or 32% less than October 1992.

Question 33. Legislation has been introduced in both the House and the Senate (H.R. 3269 and S.1649) to require that under VA's work rate standards for adjudication personnel, work credit may not be received until the decision on the claim becomes final. Under the legislation, a decision would be considered final only after the claimant has exhausted the right to appeal the regional office denial of the claim or failed to exercise that right. Concerns have been raised by those who support this legislation that VA's present system of work measurement standards encourages and even rewards high volume, low quality results. They argue that these standards provide incentive for "churning" cases, rather than emphasizing quality, and that they do not accurately reflect the amount of time it takes to process a claim. Please provide your views on work measurement standards generally and the provision in these bills and describe what, if any, plans you have for revising these standards within VBA.

Response. Our Claims Examiners work under performance standards that emphasize quality and timeliness, and to a lesser extent, production. The standards define how well we meet the expectations of the position. The proposed legislation could delay performance feedback by delaying the credit for completed work for as much as a year. Neither appropriate rewards nor corrective training could be proximately tied to performance.

Staffing is determined during the annual budget process and is based on workload received, completed, and anticipated. The end product credit taken by each adjudication division when it completes a case is at the core of the staffing requirements part of the budget process. To protract the process by extending end product counts for an additional year would make the budget process much less responsive to workload changes and trends.

We revise our adjudication measures on a regular basis. The work rate standard for each end product has been studied and revised for each of the last five years to be sure the work rate credit accurately reflects the changes in processing. As the current Benefits Delivery Network (BDN) is replaced by the modernized VETSNET system over the next three years, we'll review our measurements to modify or replace them as needed or as the technology permits.

Question 34A. For the purpose of addressing the claims backlog and the problems in the adjudication system, you established a Blue Ribbon Panel. The Panel made some substantial recommendations, which were approved by the Secretary, for solving problems in the adjudication system. Please explain in detail your plans for implementation of the extensive changes called for by the Panel's report, including the projected timeframe.

Response. The panel made 43 recommendations, and our action plan assigned a benchmark for each of them. The plan calls for 25 of them to be completed in 6 months; 14 will take from 6 to 18 months, with four of them

scheduled for the longer term. To implement the recommendations, we need to look at the organization of our Adjudication Divisions, particularly the Rating activity, in order to increase the number of decision makers. Development of our five key Stage I modernization initiatives is absolutely essential. Training will be expanded and refined, possibly by computer-based training and video conferencing. We'll need better and more timely Compensation and Pension examinations. Our liaison with other involved Government agencies needs improvement, and finally, we've got to communicate more with the veteran customer.

However, I don't see the Panel's recommendations as the end-all. We continue to evaluate our problems and to look for new and better ways to do things.

Question 34B. What overall impact do you believe implementation of these recommendations will have on the claims backlog and, specifically, if VBA implements all of the recommendations of the Blue Ribbon Panel, what is the estimated number of days that the current average processing time will be reduced?

Response. If we accomplish all that the Panel called for, the backlog will be reduced. The timeliness of C&P processing will also improve. However, we still need to test and measure implementation of the Panel's recommendations and action plan before we can fully assess the overall impact.

Question 35. In your view, which recommendations of the Blue Ribbon Panel will have the most positive impact on the timeliness of the claims process?

Response. The Panel felt that all of the recommendations and the whole action plan are needed to help improve claims processing and I agree.

Question 36. What is the estimated cost of implementing all of the recommendations, in your view, will the implementation of these recommendations be cost-effective?

Response. Many of the recommendations can be accomplished within our current resources such as the training or the manual and regulation review, but a number of the other actions are dependent upon the modernization schedule. We won't move forward, and could move backward, if we don't adhere to the phased, interdependent stages of modernization.

Question 37. As Under Secretary for Benefits, what other solutions to the claims backlog would you propose and pursue?

Response. The Blue Ribbon Panel's recommendations and action plan cover a broad range of solutions and initiatives to address the issue of the claims backlog. The Panel is calling for a reengineering of the adjudicative process, and if its action plan is implemented timely and completely, significant inroads will have been made. In the meantime, we are pursuing our own initiatives, through training, through various reengineering possibilities, and through the modernization media. Our quest for new and better ways to do things won't stop.

Question 38. In your view, is there any legislative action that Congress could take to improve the VA adjudication process?

Response. Congressman Slattery has drafted legislation which would, in part, give VA discretionary authority to require or not require that certain classes of beneficiaries file an annual eligibility verification report (EVR). We have expressed support for this provision.

About 76 percent of our pension beneficiaries have either no income or income only from social security. We can monitor them through our computer matching programs with the Social Security Administration and the Internal Revenue Service, without annual EVRs. Each year we would send them a letter reminding them that they are required to report to VA changes in income, dependency, net worth, and any other factor that could affect benefit entitlement. The remaining 24 percent of pension beneficiaries would continue to receive annual EVRs to retain eligibility for benefits. In reducing the required number of EVRs by 76 percent, we could reduce the number of FTEE required to process them, and redirect resources to other areas requiring attention.

Congressman Slattery's bill had not been formally introduced as of the date of adjournment of the first session of the 103rd Congress.

Question 39. What role do you see technology playing in the ongoing effort to achieve a more efficient and effective adjudication process?

Response. Since its inception, the principal goal of the VBA modernization program has been improvement of service to the veteran. Our current antiquated systems have been a gross impediment to progress.

Benefits from new technology will occur incrementally. Some come fairly quickly. For example, the installation of personal computer workstations occurring right now provides each adjudicator or veterans benefits counselor his or her own device to access all functions available. This will mean no more device sharing; no more need to leave one's desk to access a second system. The new technology gives us capabilities which were simply out of the question in the past. We have, for example, just begun implementation of a much-improved letter generation system for Compensation and Pension. The new system integrates word processing and data processing and takes advantage of user friendly features to significantly reduce the time to produce quality letters. Of even more significance is the fact that we now have the technology available to implement a completely redesigned adjudication process. Over the next few years we will make use of expert systems and image processing to support the reengineering of our business processes. This will allow our staff to focus on services to veterans rather than on compensating for the inadequacies of fragmented and overlapping ADP systems. Using computers, rather than people, to track claims and ensure compliance with complicated rules promises to bring substantial improvements in quality and effectiveness.

Question 40. Would you be inclined to set up new pilot programs at individual regional offices to test different ways of doing things to find out what might work best? For example, the team approach to claims processing, which I understand has been tried at various stations, including the New York and Oakland regional offices, has apparently worked well. Do you plan to try similar programs at other regional offices or set up other types of programs elsewhere?

Response. I will pursue any way of doing business better and smarter, and welcome self-directed initiatives such as those being conducted in New York, Oakland, Portland, Jackson, Muskogee, and others.

Seven stations are working on variations of combining the Adjudication and Veterans Services activities to promote better service.

I feel very positive about the initial efforts, and will watch closely for the results of the pilots. Just as soon as an initiative proves successful, it will be exported for use throughout the country.

Question 41. What impact, if any, do you believe national health care reform will have on claims processing?

Response. The actual impact in terms of cost, resources, workload, and delivery of services cannot be determined at this time. The Department is developing an implementation plan for health care reform. VBA is actively participating in this effort. We will make every effort to mitigate the impact on our customers.

Question 42. The BVA also faces a tremendous backlog. Do you see any relationship between the problems of VBA and BVA and, if so, what suggestions do you have for how VBA and BVA might work together to address their backlog problems?

Response. General Counsel staff meet with us weekly to discuss specific cases as well as workload and backlog issues.

We'll shortly implement procedures allowing appeals to be added to BVA's docket without requiring them to take possession of the claims folder at the same time. Under this "Advance Docketing," appeals will be added to the docket immediately following receipt of them at the regional offices. The claims folders will remain at the regional offices until BVA is ready to review of the case.

We will continue to emphasize the importance of resolving locally every issue possible, with particular attention to resolving reasonable doubt in the claimant's favor; and the necessity of ensuring that all appropriate development has been completed and that all evidence received has been considered before submitting cases to BVA. We also will continue to encourage regional offices to monitor remanded appeals for any patterns of inadequate development that could be corrected. Finally, we are continuing monthly conference calls to ensure that all regional offices comply with any precedential changes resulting from COVA decisions.

APPEAL STATISTICS

	FY1990	FY1991	FY1992	FY1993
Appealable Issues Filled at ROs* (C&P, Education & VR&C)	4,453,129	4,250,754	4,200,080	4,379,747
NODs filed at ROs	66,127	67,442	69,928	65,676
Appeals to BVA	43,808	43,093	38,229	38,147
Appeals to CVA	1,283	2,248	1,691	1,314

* Excludes EPs 170, 172, 070, 173, 174, 500, 510, 600

Question 43. From the VBA perspective, what ideas do you have for unifying the various components of VA—VBA, BVA, and General Counsel's office—for purposes of adjudication and appeals? For example, what could be done to improve the communication among these three entities, particularly with respect to decisions of the Court of Veterans Appeals?

Response. There is frequent informal communication between personnel of the Judicial Review Staff of the Compensation and Pension Service, BVA's Counsel to the Chairman, and General Counsel's Professional Staff Groups III and VII. One of the ongoing liaison activities is a weekly meeting about Court decisions and their impact on VA.

Question 44A. Vice President Gore's proposal under the National Performance Review calls for a 12 percent reduction in FTEE government wide. Please describe how you would deal with this significant force reduction if it becomes necessary.

Response. The Department has several initiatives under discussion to implement National Performance Review proposals. These initiatives are expected to effect gradual reduction in the size of our workforce by reducing supervisory layering and unnecessary regulations; eliminating obstacles in procurement, budgetary and personnel systems; and increasing productivity while lowering the cost of doing business.

Even before that report, though, VBA identified initiatives for working smarter. We are trying to speed decisionmaking by eliminating bottlenecks, delegating decisionmaking and improving customer communications.

Question 44B. How would the reduction in FTEE under the plan for reinventing government impact on the implementation of the recommendations of the Blue Ribbon Panel?

Response. We are working within the thrust of the reinvention concept. We are getting more decisionmakers involved, reducing indirect labor, getting down to basics. Our reengineering and modernization efforts are directed toward putting the customer first. The scope of a number of the recommendations in the National Performance Review closely parallel recommendations of the Blue Ribbon Panel.

Question 45. What is your view on using VBA personnel according to their function rather than their assigned program—for example, do you believe that certain services now performed by personnel in the Loan Guaranty Service, such as phone contacts and answering loan-status inquiries, could be performed by VBA personnel in the Veterans Services Division who now perform similar functions with respect to other benefits?

Response. Veterans Benefits Counselors (VBCs) do provide assistance on all VA benefits and services, including Loan Guaranty.

Veterans Benefits Counselors issue Certificates of Eligibility. They will be handling calls coming in as a result of Loan Guaranty's special campaign to urge about 2.1 million veterans to apply for interest rate reduction refinancing loans. Veterans Benefits Counselors answer calls from veterans, lenders, builders, and realtors. At certain stations, loan guaranty management has requested that very technical inquiries be referred to loan guaranty specialists.

Training, communication, and coordination between the two divisions are essential and ongoing elements, and then the whole process is monitored to try to make it as effective as possible.

Question 46. In your view, is Statistical Quality Control working effectively?

Response. VA's traditional statistical quality system is a sound one and has served us well for many years. When viewed from the perspective of total quality management, though, we learned that quality could be acceptable and within limits, but still not meet veterans' expectations. It is not sufficient to find and correct errors; errors must be prevented. Quality management must emphasize quality-mindedness, not just quality control.

As a result, our Veterans Assistance Service is restructuring its quality control system to stress quality over quantity, and to include consumer expectations as part of the overall program. For example, they changed the measurement of timeliness from specific acceptable quality levels (e.g., 90 percent of visitors interviewed within 15 minutes of arrival) to a goal-identified measurement (e.g., personal interviews will be initiated within 20 minutes).

In our Compensation and Pension and Education programs, we have instituted a new quality assurance program to measure the quality of adjudication division programs. It computes national accuracy rates and evaluates individual station quality levels. Evaluations are now customer-based and are broken down into three primary areas: (1) Did we pay the claimant the right rate for the right period of time? (In other words, was our decision correct?); (2) Was our notification (including an explanation of any recourse available to the claimant if he/she disagrees with our decision) clear, complete, and understandable?; and (3) Was our development and control of the claim sufficiently accurate to enhance the timeliness of our claim processing?

At this time, it is too early to tell how well the new program is working. It will be some time before enough station reviews have been completed to provide an accurate data base to evaluate the effectiveness of the review system.

Question 47. Does VBA compile data showing the overall quality of adjudication—in other words, a national error rate—and, if so, what is the national error rate?

Response. We do not have a "national error rate" in the traditional sense. However, the Compensation and Pension Service and the Education Service gather data showing the quality of adjudication when station reviews are conducted. Since the start of the quality assurance reviews approximately one year ago, these data have been compiled by program. For example, we are accumulating data showing the quality of processing actions for compensation claims, pension claims, dependency and indemnity compensation (DIC) claims, and Montgomery G.I. Bill claims.

In the Education area of benefits delivery, we monitor payment of benefits and service to the claimant. For FY 1993, the *payment* success rate for all education programs was 94.20 percent. This means that payment was correct in 94.2 percent of the cases we reviewed. The *service* success rate for all education programs in FY 1993 was 87.15%. The service category includes

development, calculation of eligibility period, and notification to interested parties.

The Compensation and Pension Service has a program that measures the overall quality of adjudication through two separate reviews. The first review is a national accuracy review that measures the success rate of the adjudication of claims for each fiscal year by looking at effectiveness in three key areas. For FY 1993 in the category of decision accuracy, the success rate was 96.5 percent; in the control and development category, the success rate was 96.0 percent; and in the notification category, the success rate was 93.8 percent. The second review measures the accuracy of current active payments. For FY 1993, the success rate was 98.2 percent.

Question 48. In terms of budget priorities, how important is employee training in your view?

Response. Training is very important. It is one of the three major components of our strategic plan and, as such, is given a high budget priority.

Question 49. Do you have any plans for changing or expanding VBA's training program? If so please explain.

Response. Not immediately, but over time our training program will evolve with the modernized environment and changed work processes. Its design will incorporate new technologies. Instruction will be dynamic and interactive, and will seek to use the most effective delivery methods. Instruction will be evaluated in terms of the knowledge gained as well as the improved

performance on the job. Finally, it will serve to validate our work standards and measurements.

Question 50. If confirmed, would you institute any changes in VBA staff training to increase cross-training?

Response. VBA's business reengineering effort will examine existing work processes, staffing structures, position descriptions and the availability of new technologies to support business activities. The outcome of these efforts will be redesigned work processes and a more flexible, cross-functional work force. The training program will incorporate the requirements of the redesigned systems and structures. In the interim, cross-training will be utilized as needed.

Question 51A. Please provide your assessment of the training program for adjudication personnel at the Veterans Benefits Academy?

Response. VBA's Compensation and Pension Service has provided centralized training for key adjudication personnel for almost four years. The results have been consistently positive, and regional offices have come to rely on this training. Through centralized training courses with standardized curricula and training materials, the Compensation and Pension Service has greatly assisted the regional offices with the burden of training new employees and providing ongoing refresher training. In addition to providing consistent information about VA benefit programs, the training ensures that adjudication employees are given a standardized interpretation of laws, regulations, and procedures. In the long run, the training programs given to adjudication personnel will improve the quality and timeliness of benefits and services to veterans and their dependents. Since 1990, the C&P Service has trained 1,284 adjudication personnel, of whom 616 (48%) were newly hired Veterans Claims

Examiners. Our training also includes periodic return trips for advanced training, special program training, recurring refresher training, training for senior adjudication personnel, and management training for first-line supervisors.

Question 51B. If you are confirmed as Under Secretary, will VBA continue to operate the Academy and, if so, would any changes be made to the training program?

Response. VBA will continue to operate the Academy as a state-of-the-art training facility and will expand its mission to best meet the needs of VBA's services and staffs. Continued operation of this facility is a key aspect of our future plans and conveys the priority we place on training.

Question 52. To what extent does the training for VBA personnel who have direct contact with veterans include subjects related to the VA home loan program?

Response. Veterans Benefits Administration personnel who assist veterans with loan guaranty issues receive regular training. Loan Guaranty personnel help develop the training and assist in instructing. New Veterans Benefits Counselors are trained at the Veterans Benefits Administration Academy and the curriculum includes classes on loan guaranty benefits.

Question 53. What is your view of the role of outreach by VBA, particularly in light of the steady decline in VBA's staff in recent years, substantial increases in the demand for information and services—in large part due to military downsizing—and the adjudication backlog?

Response. My view of the role of outreach has not changed as a result of staffing declines in VBA. Outreach remains a critical element in our delivery of benefits and services to veterans and their families. The allocation of resources to perform outreach activities has been at a premium for several years. This has required us to establish priorities and to place our emphasis on reaching groups most in need of information and assistance. Our current priority outreach emphasis is on services to homeless veterans, active duty military personnel, and the elderly. The need for outreach is greater now because of military downsizing. Also, personal service during heavy workload periods should be strengthened, not sacrificed.

Question 54. What do you see as VBA's responsibility with regard to providing outreach to users of VA medical centers, outpatient clinics and vet centers, homeless centers, military installations, state employment offices, and prisons to ensure that eligible veterans are informed of their eligibility for benefits?

Response. Since 1967, we have had a legislative mandate to provide outreach services to veterans and their families. You have given us latitude in the design, direction, content and structure of our outreach initiatives and we have striven since then to conduct activities that are consistent with the Department's mission and veterans' needs.

The specific focus of our outreach activities has varied from time to time based on changes in legislation, resources, and policy emphasis involving specific groups. While no specific individual or group is excluded from outreach, our emphasis has been to target groups that appear most in need of information and assistance. Women veterans, former POWs, recently

discharged veterans, and Native Americans are a few of these target groups. The current priority outreach emphasis is on services to homeless veterans, active duty military personnel pending separation or retirement, and the elderly. Much of our outreach to these target groups is conducted at the types of facilities listed in your question. Some outreach efforts must be concentrated because of demographics, as in VBA facilities serving areas with large Native American populations.

Question 55. Do you have any plans to increase outreach capability?

Response. Not at the moment. Clearly, we recognize the need to increase our outreach to certain groups, such as homeless veterans, military personnel who are separating as a result of military downsizing, victims of radiation exposure, and Persian gulf veterans who may be suffering health problems as a result of environmental contaminants. However, we cannot be certain in the current fiscal environment whether we will be able to significantly increase our outreach capability.

Under Public Law 102-590, there is a potential for increased collaboration between VHA and VBA. Part of that potential involves the flow of limited funds from VHA to us to help pay for payroll expenses of a few VBA outreach staff.

During FY 1993, we increased our transition assistance to active duty personnel in Europe by assigning 6 VBCs to 6-month details in Germany, Italy and the United Kingdom. If we can, we'll assign similar details to the Far East.

Question 56A. Public Law 102-590 requires VA to conduct outreach services to homeless veterans, including assigning VBA employees to conduct site visits to identify homeless veterans and provide such veterans assistance in obtaining benefits. What progress has been made in fulfilling this outreach mandate?

Response. VBA recognized the importance of outreach to homeless veterans long ago. As early as February 1985, VBA regional offices were asked to identify and contact homeless service providers with local communities to emphasize the availability of VA benefits and services for homeless veterans. In 1986, as Chief Benefits Director, I asked each station to include homeless veterans as an outreach and public information programs for homeless veterans. These guidelines were updated in 1991.

VBA staff regularly visit shelters and other places where the homeless congregate in an effort to explain benefits eligibility, prepare applications and answer questions. Also, regional offices have implemented other local homeless outreach initiatives within communities. These initiatives vary from station to station and may include:

- Providing veterans benefits counseling in shelters;
- Participating on community task forces;
- Working with VHA's specialized homeless outreach teams in the inner cities and rural communities;
- Identifying qualified candidates for admission to VA's domiciliary Care for Homeless Veterans Programs and the Homeless Chronically Mentally Ill Programs; and

- Maintaining active liaison with social services agencies and community homeless advocate groups. VBA has designated regional homeless coordinators to maintain and coordinate effective liaison and coordinate referrals with other VA and non-VA service providers.

Since October 1990, VBA field personnel have:

- Made over 12,000 visits to shelters or other homeless facilities;
- Initiated over 12,800 contacts with community agencies working with the homeless; and
- Provided over 46,600 homeless veterans with one-on-one benefits counseling, claims assistance and referrals to other VA and non-VA assistance programs.

Question 56B. Do you support continuance of these outreach services, and if so, what would you need to continue the program and what plans do you have for it?

Response. I support the continuation of outreach services to homeless veterans.

It is important to realize that Public Law 102-590 calls for VBA personnel at selected VHA homeless program sites when appropriations are provided. To date, however, VBA has not received any specific appropriation or FTEE allocations as a result of this legislation.

Currently, a few stations are participating in specialized homeless programs funded by VHA. The regional offices in New York City, Pittsburgh and Waco were given funding by VHA which allowed us to assign a Veterans Benefits Counselor (VBC) to Comprehensive Homeless Centers in their jurisdictions. A few other regional offices (Cleveland, Detroit, Hartford, and St. Paul) are reimbursed by VHA for VBC support of specialized programs in their respective jurisdictions.

VHA appears to be in a position to continue to provide limited financial support for our participation in these specialized homeless projects. We are committed to continuing these and other special initiatives to the extent possible.

Question 56C. In addition to outreach services provided by VBA counselors, as required under Public Law 102-590, what role do you see VBA playing in VA's overall effort to assist homeless veterans?

Response. Some of our benefit programs—disability compensation, pension, education—aid in efforts to resolve the economic problems of homeless veterans and/or are preventive measures against homelessness. Another economically related program that helps to prevent homelessness is the Fiduciary and Field Examination Program. This program identifies and assists veterans and other VA beneficiaries who have mental or physical disabilities that place them at personal and financial risk. VBA determines the best possible fiduciary or third party payee to manage the beneficiary's funds and provide for his or her will being. Once a fiduciary arrangement is established, VBA continues to supervise the use of funds.

Other more indirect VBA programs and initiatives that are part of our efforts for homeless veterans are:

- Expedited Claims—VBA, working with VHA and the National Personnel Records Center, has established a system for expediting benefit claims for homeless persons—especially when physical examinations and medical records are required.
- Directing Payments—The requirement that a VA beneficiary have a permanent address is no longer in effect. Payments can be directed to VA facilities where the veteran can receive his or her check.
- VA Acquired Properties for Homeless Providers—VA is able to sell, at a discount, foreclosed properties to nonprofit organizations and government agencies that will use them to shelter or house homeless veterans. Through the end of FY 1993, 22 properties have been purchased by homeless providers under the homeless program, and another 2 properties are being used by a VA medical center for compensated work therapy program purposes.
- Home Leasing to Homeless Providers—VBA initiated a test program (50 properties nationwide) to determine possible benefits and costs, as well as legal liabilities, of leasing properties in the VA inventory under the homeless program, rather than selling the properties as soon as possible to replenish the Loan Guaranty Program fund account. Leases have been executed for 15 of the 50 properties that were allocated for this program.
- Comprehensive Homeless Centers (CHC)—To date, VA has designated three CHCs: Dallas, Texas; Brooklyn, New York; and Pittsburgh, Pennsylvania. These Centers combine all of VA's homeless assistance resources in one organizational framework to better coordinate assistance to homeless veterans. VHA and VBA staff work together to reduce or eliminate the overlap and duplication in such areas as outreach and benefits certification and to streamline service delivery.
- Stand Downs—During FY 1993, VBA personnel participated in 25 Stand Down events. At these special two or three day events, homeless veterans obtain food, shelter, and a wide variety of other types of services and assistance.

Question 57. What is your assessment of VBA's Information Resources Management (IRM) modernization effort to date, and what are your plans and priorities in connection with the future stages of the overall modernization plan?

Response. I view the effort to date as extremely successful. We have a carefully designed architecture that provides modern hardware and development tools. We are implementing a reliable, expandable, integrated network of personal computer workstations, communications capabilities and powerful distributed computers throughout VBA. We are seeing immediate results in improved access to computer support. Now that we have hardware, we can and are developing a number of high priority, transitional applications to bring relief as soon as possible in critical areas.

The jewel in the crown of modernization is the Veterans Service Network (VETSNET). VETSNET will use state-of-the-art software engineering methods and tools. It will focus on the veteran or client and use a comprehensive, fully

integrated structure to ensure data sharing. The VBA Business Model is playing a key role in determining the strategies for our software applications. It identifies 39 goals; defines current problems, critical success factors, and a modernized concept of operations for each goal; and identifies the 203 fundamental processes necessary to perform our mission. Twelve teams of business and information systems professionals have been formed to begin the next stage of VETSNET development, addressing complete redesign of C&P information systems as first priority. Because the C&P component will be derived from the VBA corporate business model, the C&P effort will produce capabilities that can be used again as we expand VETSNET to other program areas.

Question 58. When do you foresee the modernization plan being fully integrated and functioning within VBA?

Response. VBA is committed to acquiring and implementing modernized technologies as quickly as possible. Stage I implementation will continue through 1994. Stage II technologies will be acquired during 1994. The plan calls for the completion of modernization Stage III equipment acquisition and installation in early FY 1996. Transitional applications will be implemented during 1994 and 1995. VETSNET applications, derived from the Business Model, will be implemented incrementally beginning in 1996.

Question 59. In 1992, Rep. Conyers raised some concerns with respect to VA's potential contracts related to the modernization project. Rep. Conyers requested a report on the project by GAO, which found that VA's plans to enter into a contract were premature (Acquisition of Information Resources for Modernization is Premature (GAO/IMTEC-936, November, 1992). In response to this request, VA indicated to Congress that if it were allowed to proceed on its intended schedule for the modernization plan, the plan would result in substantial savings through staff reductions. Do you believe that the current plan will result in the savings projected by VA last year? Please explain.

Response. VBA does not envision and has not promised staff reductions from modernization. We are committed to improving service quality and processing times as a result of modernization. Increased efficiency in tracking claims will reduce the time needed to process claims, even though those claims are now more complex. The modernized environment will also provide a centralized access point for all veteran inquiries and consolidate case information, policies and procedures for ready access. The modernized environment will provide greater integrity of data and improved tracking and collection of debts. All of these improvements in VBA's benefits delivery will be realized through the implementation of modernized technologies in conjunction with reengineered applications and enhanced business processes. I am confident that our approach to modernization will make it possible to meet the performance goals we have established with OMB.

Question 60. What plans do you have for ensuring that VBA meets the deadlines set under the agreement reached with Representative Conyers?

Response. The agreement between VA and OMB sets forth the goal that the entire acquisition will be completed and the system operating in 36 months. Given continued cooperation and budgetary support, we see no problem with meeting this goal. The Stage I acquisition is already complete and systems will be in operation at the last sites to be implemented early in FY 1995.

Application software development to take advantage of systems capabilities is proceeding along two paths. Transitional applications, dealing primarily with certain critical Compensation and Pension problems, will be deployed during FY 1994 and 1995. The Veterans Service Network (VETSNET) applications deployment will begin with the C&P component in FY 1996. Other components will be added incrementally in following years.

The combination of transitional and VETSNET developments is designed to accomplish the goals established with OMB for FY 1994 through 1998. Three of these transitional systems, Claims Processing System, Rating Board Automation and Control of Veterans Records, will be tested and measured at two regional offices, Baltimore and St. Petersburg, as they go online. Baseline measurements have been or are now being developed. As new software capabilities are implemented we will periodically assess their impact on the performance goals with OMB.

Question 61. What impact, if any, will meeting the schedule under the agreement have on other operations within VBA?

Response. Our modernization plan and associated implementation plans are designed for a rapid transition in technology environments with minimal impact on day-to-day operations. The implementation of Stage I technologies and systems is an example of our planning. Teams are in the field today installing Stage I technologies in our regional offices. The new technologies are being deployed in phases within each RO to minimize disruption. In like manner, we will be deploying the applications software in phases to allow a smooth transition. We expect some disruption—the training required for the new technologies and systems will take time away from routine processing—but with proper planning, this distraction should be minimal.

The agreement between VA and OMB calls for evaluation of the technologies and their impact on our business in the course of modernization implementation. As noted earlier, we will be assessing three of the key Stage I systems as they go online at two test sites. The provisions of the agreement will not have an impact on the methods we use to transition between the current and modernized technology environments.

Question 62. What is your estimate of the impact of full implementation of the modernization plan on the timeliness and quality of the claims adjudication process?

Response. It is difficult and premature to attempt to quantify the impact of full modernization at this time. We are evaluating several applications at a number of stations, but it will be at least a year before we can gauge their impact.

Question 63. Are you giving consideration to making any proposals for the revision of any VA benefits? If so, please describe the possible changes.

Response. No.

Question 64A. Do you support the basic philosophy underlying both the military disability retirement pay system and the VA disability compensation system that the Government should compensate for disabilities that arise in service, or that may be presumed to have arisen in service, without a requirement that some activity, event, or hazard in service caused the disability?

Response. The military retired pay and VA compensation systems should be considered part of a veteran's total benefits package. In most instances, VA is the only recourse available to veterans seeking recompense for injuries or diseases incurred while on active duty. Current statutory authority does not permit us to make distinctions for circumstances surrounding incurrence of a disability while on active duty, unless willful misconduct or the abuse of alcohol or drugs is a factor. It would be difficult to establish alternative criteria for granting service connection that would satisfy everyone and properly compensate all deserving persons. I believe the current system is equitable and can be administered without undue hardship to those who suffer injury or disease in service.

Restriction of compensation benefits to cause or direct performance would raise issues of the lack of alternative protection such as commercial insurance available to civilians, but not available to service members due to the unique demands of military service.

Question 64B. Do you believe that the basic philosophy of the two systems needs to be the same? Please explain your answer.

Response. Although VA and DOD maintain separate decision processes under distinct statutory authorities and have different rationales for their disability determinations, they still form complementary parts of a total system of compensation. Physical Evaluation Boards for all branches of DOD, for example, use VA's Rating Schedule in evaluating the nature and extent of disability when medical discharge from active military duty is contemplated. The two systems are inextricably linked because the law requires that a veteran waive military retired pay in order to receive VA compensation. We continue to support the current systems.

Question 65. The suggestion has often been made—particularly in the context of deficit reduction—that service connection should not be afforded for conditions that are not directly related to military duties. This was the subject of a 1989 GAO report entitled "Law Allows Compensation for Disabilities Unrelated to Military Service (GAO/HRD-8960, July 1989)." Please discuss your views about the issues, recommendations, and observations contained in the GAO report. Specifically, please describe (a) any aspects of the disability compensation program which you believe should be revised or need to be reexamined with a view toward revision, (B) any specific revisions you may support, and (C) your reasons for believing that revisions or reexaminations are needed.

Response. The GAO report was directed to Congress and provided information regarding alternative eligibility criteria for service connection. the report carefully emphasized that the findings did not indicate any fault or errors in administering the current provisions of the law. I support the current legal basis for compensation.

Question 66. Four years ago, in response to a GAO report (Need to Update Medical Criteria Used in VA's Disability Rating Schedule (GAO/HRD-89-28, December 1988)), VBA began the task of revising the schedule for rating disabilities. Please describe the progress made on this revision thus far, and the estimated date of completion of the project.

Response. It is our intention to have the revision completed by the end of calendar year 1994. The following is a status report on the revisions of each

of the body systems contained in the Rating Schedule. It is our intention to have the revision completed by the end of calendar year 1994.

BODY SYSTEM	STATUS
Genitourinary, Dental/Oral	Final revisions approved by OMB and to be published shortly
Gynecological	Final revision submitted for review and concurrence within VA
Cardiovascular, Respiratory, Skin, Endocrine, Systemic, Hemic-Lymphatic, Muscular	Proposed revisions published; final revisions in preparation
Hearing, Orthopedic, Neuropsychiatric, Eye	Proposed revisions submitted for review and concurrence within VA
Neurological, Digestive	Proposed revisions will shortly be submitted for review and concurrence within VA

Question 67. Please provide your views on the general impact of presumptions on the overall claims adjudication process.

Response. Presumptive service conception permits payments of compensation to veterans whose claims might not be resolved favorably under other provisions and requirements of law. Presumptive provisions are generally easy to administer since they usually entail straightforward eligibility criteria for granting service connection for specific diseases.

The policy decisions underlying presumptions establish eligibility for large numbers of veterans in situations where service records and medical knowledge cannot provide definitive information.

Question 68. On October 11, 1991, then Chairman Alan Cranston requested former Secretary Edward Derwinski to submit to the Senate Committee on Veterans Affairs a detailed historical analysis of the development of presumptions of service connection in the VA compensation program. The Secretary was also to relay the position of VA concerning the role and continued validity of these presumptions. The Committee has received advance copies of the first three sections of the legislative history, through 1966. The final report, which should include the complete legislative history, medical review, analysis of both the original and current policy foundations of each of these presumptions, and VA's views, has yet to be transmitted. Please indicate the current status of the report and when you anticipate that Secretary Brown will submit the final report to the Committee.

Response. I am informed that the final report was submitted to the Committee in late December 1993.

Question 69A. Concerns have been raised about the number of VHA examinations that cannot be used for purposes of a compensation or pension claim. Please indicate the percentage of examinations that are unusable by VBA and provide the reasons why they cannot be used.

Response. This topic was discussed at length by the Blue Ribbon Panel. Some representatives of the national service organizations felt that too many cases were rated on inadequate VA examinations because of time pressures, and that this was one of the reasons for the high remand rate. Other panel

members felt that the percentage of inadequate examinations ranged from 20 to 30 percent but this figure was not corroborated by reports on the subject. To verify the problem, the Panel surveyed VA examinations conducted as part of claims for Compensation and Pension benefits. Of the 177 examinations assessed, 29 percent did not conform to the Physicians Guide, the manual VA uses to ensure examinations conducted for Compensation and Pension purposes are in compliance with the Rating Schedule, and were returned to the respective VA medical center for correction. One of the Panel's action items requires that the current memorandum of understanding between VHA and VBA be expanded to include specific measures of quality.

Question 69B. Please provide your views as to the effectiveness of the Automated Medical Information Exchange (AMIE) with respect to the coordination between VHA and VBA concerning compensation and pension examinations.

Response. VBA generates most examination requests electronically, via AMIE. VHA uses AMIE to schedule examinations and print worksheets designed to prompt physicians to provide medical information essential for VBA rating purposes.

Overall timeliness of C&P examinations has improved with AMIE and the VBA/VHA memorandum of understanding. Currently, the overall average is approximately 40 days.

The majority of completed examination reports received by VBA are satisfactory. Because of various VHA technical problems, however, examination results often are not transcribed into the system. As a result, those examination reports cannot be printed at the VBA regional office and must be returned via FAX, messenger, or mail.

Both VBA and VHA recognize the need to fully implement and improve the AMIE system. An AMIE Expert Panel, comprised of VBA and VHA representatives, has been in place for approximately 18 months.

Question 70. In addition to AMIE, what other initiatives are being pursued, or would you seek to pursue, with respect to the coordination between VHA and VBA concerning compensation and pension examinations?

Response. Staff members from VBA and VHA have been working on a joint task force to revise the *Physician's Guide to Disability Evaluation Examinations* to make it "user friendly." Information in the revised Physician's Guide will be available electronically in the examination room via an AMIE help screen.

The revised Physician's Guide will provide separate pages for examination of each disability in the Rating Schedule and information for each disability concerning the specific findings, test methods, lab work, etc., required by the Rating Schedule.

The current VBA/VHA memorandum of understanding (MOU) places a high priority on timeliness of VA examinations. The Blue ribbon Panel recommended that the MOU be expanded to include quality measures. The Panel also recommended a joint VBA training effort to stress the importance of quality examinations and the basis for VBA benefits.

The Blue Ribbon Panel also recommended that the AMIE examination process be revised to allow customized examination requests.

Question 71A. In his testimony at the November 16,1993, hearing on Persian Gulf War illnesses before the Committee on Veterans' Affairs, Secretary Brown indicated that VA is giving priority to claims for disability compensation based on exposure to environmental hazards. Please explain how these claims are given priority and under what authority this is being carried out.

Response. Persian Gulf War compensation claims based on exposure to environmental agents are processed by the Louisville, Kentucky, regional office. Instructions are contained in a VBA circular, a copy of which is attached. The Secretary approved this plan. I don't believe any special authority was needed.

Veterans Benefits Administration
Department of Veterans Affairs
Washington, D.C. 20420

Circular 20-92-29
Revised
February 3, 1993

CENTRALIZED PROCESSING OF CLAIMS BASED ON EXPOSURE TO ENVIRONMENTAL AGENTS IN THE PERSIAN GULF WAR.

1. PURPOSE. This circular contains revised instructions for centralized processing of claims based on exposure to environmental hazards in the Persian Gulf, during the Persian Gulf War, in the Department of Veterans Affairs Regional Office (VARO) in Louisville. Paragraph 5a has been revised to set conditions under which regional offices with jurisdiction over the claimant's address may award benefits prior to transfer of the file to VARO Louisville. Paragraphs 5f and 6c have been revised to establish end product credit for each station in these situations. Paragraph 5h has been added to clarify reporting requirements under the Environmental Agent Review (Circular 21-91-12, RCS 20-0843). Paragraph 3 has been amended to show the publication date for M-10, Part III.

2. GENERAL. There is significant concern among Persian Gulf War veterans about the effects of environmental hazards to which they may have been exposed during service in the Middle East, such as exposure to oil well fires in Kuwait. In response to these concerns, the Department of Veterans Affairs (VA) has taken steps to provide treatment for the veterans and to gather data regarding their health problems. The Veterans Health Administration (VHA) has established special environmental medicine referral centers in VA Medical Centers (VAMC) in West Los Angeles, Houston and Washington, DC, and the Veterans Benefits Administration (VBA) has established a system to track those cases in which the claimant believes that exposure to environmental agents resulted in disability or death.

3. ENVIRONMENTAL AGENTS. The most complete list of environmental hazards can be found in VHA Manual M-10, Part III, Chapter 1, dated December 7, 1992. Additionally, when a veteran files a claim for benefits based on exposure to environmental hazards during the Persian Gulf War, the veteran should be encouraged to seek assistance from the local VA medical center and to obtain a Persian Gulf veteran protocol examination and enroll in the Persian Gulf health registry.

4. CENTRALIZATION OF CLAIMS. Since the number of claims based on exposure to environmental agents from veterans of Operations Desert Storm/Desert Shield has been low, individual regional offices may see very few of them. Centralizing the processing of these claims into a single regional office will allow rating specialists in that office to develop experience and expertise in rating these special claims. It will also make it easier for VBA to identify patterns and common health problems which may appear among veterans who served in the Persian Gulf.

5. REGIONAL OFFICE RESPONSIBILITIES

a. Each VA regional office (RO) is responsible for identifying claims that allege disability or death from exposure to environmental agents while in the Persian Gulf area. Once such a claim has been identified, RO personnel will attach a flash to the outside of the claims folder indicating that it contains an environmental hazard claim from a Persian Gulf War veteran or survivor (see Exhibit B). Then the RO will transfer the claims folder to VARO Louisville, to the attention of the Adjudication Officer, as quickly as possible, and notify the claimant that the claim is being transferred and the reason for the transfer (see sample letter, Exhibit A). The original station may adjudicate the claim for any condition not related to exposure to an environmental hazard before transferring the file to VARO Louisville, but only if award action can be taken without delay or development and only if it will result in expedited payment to the veteran.

b. Claims based on exposure only with no residual disability claimed as a result of that exposure will not be transferred to VARO Louisville. The regional offices will write to the claimants to request that they specify the alleged disability. If this specific information is subsequently received, the folder then may be transferred to Louisville.

c. The RO with jurisdiction over the the claimant's place of residence will maintain a permanent charge card in the file bank showing "PGW Environmental Hazards Claim" and the date that the file was permanently transferred to VARO Louisville.

d. The sending station will advise VARO Louisville of the transfer via E-mail prior to the actual transfer. VARO Louisville will alert the sending station after ten workdays if the claims folder has not been received so that follow-up action can be initiated.

e. If no development has been initiated at the time the claim is identified, the claims folder will be permanently transferred to VARO Louisville as soon as possible. Prior to transfer, the RO will dispose of any pending education issues.

f. If development has already been initiated on the environmental agent claim, the RO will ensure that copies of all development letters are in the claims folder prior to transferring it to VARO Louisville. In situations where an award can be made without delay or development, the originating office may take the existing 110 or 120 end product before transferring the file. In all other cases the pending issue controls on compensation or pension related issues will be disposed of by the original RO via the PCAN command. Completed examination reports and other evidentiary documents which are subsequently received will be forwarded to VARO Louisville for inclusion in the claims folder.

g. When VARO Louisville determines that a VA examination is needed, it will forward an annotated examination request to the RO of jurisdiction over veteran's residence (see paragraph 6f). That RO will forward VA form 21-2507, Request for Physical Examination, to the appropriate VAMC via the Automated Medical Information Exchange (AMIE) system. When the VAMC returns the completed examination, the RO will send it to VARO Louisville for association with the claims folder.

h. Since not all environmental hazard claims will be related to service in the Persian Gulf, regional offices will continue to submit the monthly report on environmental hazard claims it has completed (RCS 20-0843, Circular 21-91-12). VARO Louisville will be responsible for claims completed by their staff. Negative reports are required.

6. VARO LOUISVILLE RESPONSIBILITIES

a. VARO Louisville will maintain permanent jurisdiction of claims folders in which Persian Gulf War veterans and survivors claim disabilities or death due to exposure to environmental hazards and will be the office of jurisdiction for all compensation and pension issues raised by those claimants. When VARO Louisville receives a claims folder containing a claim for disability or death due to exposure to environmental hazards, the claims folder should already have a flash affixed to the front (see Paragraph 5a).

b. The Rating Board Section Chief in VARO Louisville will be the designated contact point for coordinating the activity with respect to these cases; the telephone number is FTS (502) 582-6214.

c. VARO Louisville has final responsibility for determining whether a claim is based on exposure to environmental hazards in the Persian Gulf. If it is determined that a claim is not based on environmental hazard exposure, that the veteran served elsewhere than in the Persian Gulf, or that the claim is based on exposure only, the claim will be returned to the RO of jurisdiction over the claimant's residence for processing. Once the claim is accepted, VARO Louisville will establish the proper end product using the original date of receipt of the claim in VA. If the regional office has taken an end product due to award action, VARO Louisville will establish an end product 120 using the original date of receipt of the claim.

d. For education claims (chapters 32 and 106) which must be worked from the claims folder, VARO Louisville will temporarily transfer the claims folder to the RO having jurisdiction over the training site for expedited processing.

e. When a veteran claims disabilities of a vague or generalized nature, VARO Louisville will request a VA medical examination, since such complaints might, on examination, result in a diagnosis of specific conditions. The examining physician will be asked to elicit as much information as possible regarding the identity of the environmental agent to which the veteran claimed exposure. In the absence of specific allegations in individual claims, rating specialists should be alert to the possibility of an underlying chronic illness.

f. In a case where a physical examination is required, VARO Louisville will complete VA Form 21-2507 and send it to the RO having jurisdiction over the claimant's residence. The examination request will be prominently annotated, "PGW Environmental Hazards Claim" in the "Remarks" section (block 18) for ease in identification and expeditious handling. If the claims folder contains material which should be made available to the examining physician, it will be temporarily transferred to the RO of jurisdiction over the veteran's residence.

7. HEARINGS AND APPEALS

a. Post-decision hearings. If the claimant requests a post-decision hearing, the Hearing Officer in the office having jurisdiction over the claimant's residence will conduct the hearing. After the the hearing has been conducted, the Hearing Officer will notify the claimant of his or her decision then return the claims folder to VARO Louisville for any necessary action.

b. Appeals. VARO Louisville will retain jurisdiction over all compensation and pension issues with which a claimant may file a Notice of Disagreement and will maintain the Appeal Tracking System (ATS) records. This includes all issues decided by VARO Louisville, not just those based on environmental hazards. The flash (Exhibit B) will remain on the outside of the claims folder, and VARO Louisville will retain permanent jurisdiction, until all appeals are resolved or all appeal periods have expired and the decisions become final.

c. Travel Board Hearing. If an appellant requests a hearing before the traveling section of the Board of Veterans Appeals (BVA), the hearing will be conducted at the regional office having jurisdiction over the appellant's address. As soon as the Louisville RO receives a request for a hearing before the traveling section, it will inform the RO of address jurisdiction by telephone or E-mail to place the case on its docket of cases to be heard before the traveling section. VARO Louisville will temporarily transfer the claims folder to that office shortly before the date scheduled for the hearing. (It is imperative that the RO of address jurisdiction inform VARO Louisville of the date scheduled for the hearing and maintain a record that the claim is a PGW environmental hazard claim located in Louisville.) After the hearing is completed, the folder will be returned to Louisville for update of the ATS and transfer to the BVA in Washington, D.C. Transfers between the regional offices in connection with travel section hearings will be accomplished by overnight delivery service.

8. POINT OF CONTACT. Direct any questions regarding this circular to the Regulations Staff, Compensation and Pension Service (211B), by calling FTS (202) 233-3005.

9. RESCISSION. This circular rescinds Circular 20-92-29, dated December 7, 1992.

D'Wayne Gray
Under Secretary for Benefits

Distribution:
SS (213A)

CO: RPC 2900
FLD: VBAFS, 1 each (Reproduce and distribute based on RPC 2068, plus VBC, 1 each)
EX: ASO and AR (included in RPC 2068

Circular 20-92-29
Revised

February 3, 1993

SAMPLE LETTER

NAME
ADDRESS
ADDRESS
ADDRESS

CLAIM NUMBER
NAME OF VETERAN

Dear [XXXXXXX]:

This letter is to acknowledge receipt of your claim for benefits based on (disability/death) resulting from exposure to environmental hazards during military service in the Persian Gulf.

As part of its program to monitor the possible health effects of exposure to environmental agents in the Persian Gulf, the Department of Veterans Affairs (VA) has designated its regional office in Louisville, Kentucky as the office to process these claims. Accordingly, we have transferred your records there. That office will advise you further about your claim as it becomes necessary.

You may direct any correspondence or evidence concerning your claim to the VA Regional Office, 545 South Third Street, Louisville, KY 40202. Please be sure to include your VA claim number on all correspondence. While the Louisville Regional Office will be responsible for processing your claim, this office remains available to help you if you have questions concerning your claim or veterans' benefits in general.

Sincerely yours,

[NAME]
ADJUDICATION OFFICER

February 3, 1993

Circular 20-92-29
Revised

SAMPLE OF FOLDER FLASH

The following represents a sample of the folder flash to be used on Persian Gulf environmental agent cases. Create the flashes on white paper using the wording shown here, with lettering large enough to indicate prominently that the claim involves PGW environmental agents.

PERSIAN GULF

WAR

ENVIRONMENTAL

HAZARD CLAIM

VARO LOUISVILLE (327)

Veterans Benefits Administration
Department of Veterans Affairs
Washington, D.C. 20420

Circular 20-92-29
Revised
Change 1
August 19, 1993

CENTRALIZED PROCESSING OF CLAIMS BASED ON
EXPOSURE TO ENVIRONMENTAL AGENTS IN THE PERSIAN GULF WAR

1. PURPOSE. This change is issued to add instructions for notifying local Vocational Rehabilitation and Counseling divisions when a claims folder is permanently transferred to the Louisville Regional Office for processing of a claim from a Persian Gulf War (PGW) veteran based on exposure to environmental agents.

2. Circular 20-92-29, Revised, dated February 3, 1993, is changed as follows:

Page 3, after paragraph 5h, add the following:

"i. Before transferring the claims folder to the Louisville RO, the original RO will review to determine whether a chapter 31 folder exists. If one does exist, send notification to the local Vocational Rehabilitation and Counseling (VR&C) division that the claims folder is being permanently transferred to the Louisville RO for processing of a PGW environmental hazards claim under the authority of this circular. The VR&C division will then take steps to ensure that the chapter 31 records, including any computer master records, are properly updated."

R. J. Vogel
Deputy Under Secretary for Benefits

Distribution: CO: RPC 2900
SS (213A) FLD: VBAFS, 1 each (Reproduce and distribute based on RPC 2068, plus VBC, 1 each)
EX: ASO and AR (included in RPC 2068)

LOCAL REPRODUCTION AUTHORIZED

WANG VERSION E-MAILED ON AUGUST 23, 1993

Veterans Benefits Administration
Department of Veteran Affairs
Washington, D.C. 20420

Circular 20-92-29
Revised
Change 2

CENTRALIZED PROCESSING OF CLAIMS BASED ON
EXPOSURE TO ENVIRONMENTAL AGENTS IN THE PERSIAN GULF WAR

1. PURPOSE. This change is being issued to instruct that the military records specialists at the regional offices will assist the Louisville Regional Office in obtaining medical records held by reserve units.

2. Circular 20-92-29, Revised, dated February 3, 1993, as amended by Change 1 of August 19, 1993, is changed as follows:

Page 3, after paragraph 5i, as added by Change 1, add the following:

"j. Inasmuch as military medical records in the possession of reserve or National Guard units may be difficult to obtain, the military records specialist in each regional office will be prepared to provide all possible assistance in locating and requesting these records. Responses to requests for assistance will be channeled through the military records specialist in the Louisville Regional Office. The telephone number is (502) 582-6123."

R. J. Vogel
Deputy Under Secretary for Benefits

Distribution: CO: RPC 2900
SS (213A) FLD: VBAFS, 1 each (Reproduce and distribute based on RPC 2068, plus VBC, 1 each)
EX: ASO and AR (included in RPC 2068)

LOCAL REPRODUCTION AUTHORIZED

Question 71B. At the November 16,1993, hearing, Secretary Brown also indicated that 79 Persian Gulf War veterans have been awarded service-connected disability compensation on the basis of exposure to environmental hazards during service in the Persian Gulf. Please provide a brief description of the conditions for which these veterans have been afforded service connection.

Response. As of December 31,1993, 84 Persian Gulf War veterans have been granted service connection for disabilities which they believe resulted from exposure to environmental hazards in the Persian Gulf. Of these, 66 are service-connected for breathing problems; 10 are service-connected for skin conditions; 7 are service-connected for other conditions, such as headaches and vertigo; and 1 is service-connected for chronic fatigue syndrome.

Question 71C. For those claims that were filled on the basis of exposure to environmental hazards and denied, what were the most frequent reasons for denial?

Response. The primary reason service connection cannot be granted is that a large number of claims are based on exposure only, without specifying a disability; for example, only nonspecific residuals from specific environmental agents are alleged, such as exposure to smoke from oil well fires. Other reasons for denial of service connection in these claims are a disability's not shown by the evidence of record, including VA examination, or an acute condition was shown without any residual disability.

Question 71D. In your view, what new authority, if any, would VA need to facilitate the granting of service connection to PGW veterans in those cases that had previously been denied?

Response. Current legal authority is adequate to evaluate Persian Gulf War veterans' claims. What is needed is a better understanding of the nature of the illnesses suffered by Persian Gulf War veterans, the chronic residuals and relationship to the hazards of service in the Middle East and elsewhere We are hopeful that current medical research and clinical efforts will provide this information.

Question 71E. How many claims for service connection of chronic fatigue syndrome (CFS) have been granted (for both PGW and non-PGW veterans) on the basis of the new criteria set forth in VA training letter 93-5?

Response. On November 9,1993, VBA issued guidelines to all regional offices detailing the criteria which doctors must use to make a diagnosis of chronic fatigue syndrome. Since that time, one veteran of the Persian Gulf War has been granted service connection based on a diagnosis of chronic fatigues syndrome.

Question 71F. Does VA plan to establish a diagnostic code for CFS in the schedule for rating disabilities?

Response. Yes, we will amend the rating schedule to add a specific diagnostic code for chronic fatigue syndrome. However, until then, we provided rating specialists with other coding instructions to cover CFS.

Question 72A. Please outline the impact the decision of the Court of Veterans Appeals in Combee v. Brown will have on issues related to claims for service connection involving exposure to radiation.

Response. In the *Combee* decision, the Court essentially held that the list of radiogenic diseases contained in 38 CFR 3.311 b is exclusive and that a veteran may not establish direct service connection, solely on the basis of radiation exposure, for a disability that is not one of the radiogenic diseases enumerated in that regulation. This decision affirmed our current policy and regulations.

Question 72B. What impact, if any, does the decision in Combee have on the way in which cases involving other presumptions are adjudicated?

Response. The central issue of the *Combee* decision was not presumptive service connection, but service connection under 38 CFR 3.311 b, which provides criteria and procedures for establishing direct service connection due to radiation exposure. We see no impact on cases involving presumptions of service connection under any other provisions.

Question 73A. Section 3 of the Veterans' Radiation Exposure Amendments of 1992 (Public Law 102-578) requires VA's Advisory Committee on Environmental Hazards to conduct a review of the scientific evidence in order to determine whether there were activities that occurred before January 1, other that the specific nuclear tests or occupation activities referred to in Public Law 98-542, that resulted in veterans being exposed to ionizing radiation and whether adverse health effects have resulted from such exposure. Based on that report, the Secretary was required to identify the activities, if any, that VA will investigate further and prepare a plan for the investigation, and report by December 1,1993, to the Veterans' Affairs Committees on the investigation and plan and provide a copy of the report of the Advisory Committee. What is the current status of this report and when do you anticipate that it will be delivered to the Committees?

Response. At this time, the Acting Under Secretary for Health is reviewing the report of the Advisory Committee in order to make recommendations to the Secretary.

Question 73B. Public Law 102-578 also requires VA to "direct the Advisory Committee on Environmental Hazards to review pertinent scientific data relating to bronchioalveolar carcinoma to determine whether such disease entity should be considered to be radiogenic" and report its findings to the Secretary. The Secretary was then to submit a report to the Committees on Veterans' Affairs by April 1,1993, setting forth the Secretary's decision concerning whether presumptive service connection for this disease should be established for radiation-exposed veterans. What is the current status of this report and when do you anticipate that it will be delivered to the Committees?

Response. The report to the Committee has recently been signed by the Secretary and is pending clearance by the Office of Management and Budget.

Question 74. Under the requirements of the Agent Orange Act of 1991, VA has made several decisions this year concerning presumptive service connection for certain diseases based on exposure to herbicides. Please describe in detail your plans for VBA's implementation of those decisions and the general timeframe for completing all related actions (including adjudicating all claims that are pending in light of the decision in Nehmer v. VA). Include information on the instructions that will be provided to regional offices for adjudicating claims that are currently pending and claims field in the future.

Response. On September 28,1993, a VA proposed rule to establish presumptive service connection for Hodgkin's Disease and porphyria cutanea tarda (PCT) was published in the Federal Register. A 30 day comment period was allowed and final rulemaking has been initiated. At this time, the final rule is with OMB for clearance.

VBA has also begun the rulemaking process to establish presumptive service connection for multiple myeloma and respiratory cancers. This proposed rule is with OMB for concurrence prior to publication.

Additionally, Secretary Brown has signed a notice explaining that VA declines to find a basis for presumptive service connection for other diseases reviewed by the NAS and that both prospective and retroactive payment of benefits will be precluded pursuant to the Nehmer stipulation. This notice was published in the Federal Register on January 4,1994.

At the same time Secretary Brown announced his decisions to permit presumptive service connection for the new conditions, he expressed his commitment to contacting veterans who may now be eligible for VA benefits. VBA and VHA are compiling lists of veterans who have either sought medical care or have filed disability claims. VBA will begin to contact individuals identified as having potential entitlement to benefits as soon as possible. We project that approximately 30,000 veterans cases will be reviewed in response to our contact efforts and final rulemaking. The Compensation and Pension Service is preparing a circular to provide instructions for reviewing these cases.

Question 75A. Earlier this year, the U.S. Court of Appeals for the Federal Circuit upheld the decision of the Court of Veterans Appeals in Gardner v. Brown, holding invalid VA's interpretation of section 1151 of title 38. This decision—finding that VA had interpreted the statute too restrictively and striking down VA's implementing regulation—could potentially result in hundreds of significant retroactive awards for veterans who previously were denied benefits under section 1151. Please provide an update of the post-Gardner situation within VBA, including any actions VBA has taken or plans to take with respect to this decision.

Response. The Solicitor General filled a petition for *certiorari* with the U.S. Supreme Court on January 11. We will continue our moratorium on adjudicating denials of issues under 38 U.S.C. 1151. We also are working with the Office of the General Counsel to develop a legislative proposal amending section 1151 to enact a more equitable solution, protecting the interests of both the veterans and the Government.

Question 75B. How would you propose that VA handle the processing of reopened and original claims for disability compensation under section 1151?

Response. Please see answer to 75A.

Question 76. The treatment of veterans suffering from PTSD is a long, difficult, and immensely important process to help them return to productive and content civilian lives. I strongly support efforts to provide veterans suffering from PTSD with high quality treatment and disability compensation to assist them in their recovery. However, concerns have been raised that paying disability compensation for PTSD creates a situation that potentially inhibits the treatment process. If a veteran undergoes treatment for PTSD and makes substantial progress in overcoming the illness—as we hope will

happen—the veteran risks losing a portion of his or her disability compensation. Do you feel that disability compensation may inhibit PTSD treatment and, if so, how would you address this problem?

Response. We do not believe that receipt of compensation for PTSD generally interferes with medical care or acts as a disincentive to seek medical treatment. We do hope that it in some way encourages the veteran to obtain and continuously follow treatment.

A reduction in compensation for PTSD or any other neuropsychiatric disease is not to be made unless the medical evidence demonstrates sustained improvement in the actual condition. The results of a single examination are not sufficient evidence upon which a reduction may be based. Likewise, a report showing improvement in a veteran's social or employment adaptability may not serve as the basis of a reduction without the necessary medical evidence showing sustained improvement. Any reduction in compensation, upon which a veteran has come to rely for at least part of his or her sustenance, may cause the disability to worsen, and if the veteran is undergoing treatment, may have adverse effects on his or her progress. Therefore, all evidence is reviewed carefully and thoroughly before deciding to reduce compensation.

Question 77B. Because the previous VA directive clearly conflicted with the underlying statutory provision, there are many claims that could potentially be reopened on the basis of clear and unmistakable error—the error being that the prior denial of service connection for PTSD was based on an invalid manual directive. What, if anything, is currently being done with respect to these prior denials that were based on the incorrect manual provision.

Response. We do not agree that our instructions have ever conflicted with the statute or that there have been a large number of claims incorrectly adjudicated and subject to revision on the basis of clear and unmistakable error. I would like to set the record straight on the alleged invalid directive.

We agree that section 1154 of title 38, United States Code, requires that we take into account the circumstances of a veteran's service. This is a rule of general applicability in all compensation claims. In PTSD claims in particular, our instructions have consistently included provisions defining the relationship of combat to inservice stressors.

In DVB Circular 21-82-7 dated May 3,1982, we stated that objective evidence of a stressor included, among other things, official service records indicating medals or commendations for combat. In DVB Circular 21-86-10 of September 4,1986, we expanded this statement to say that if the alleged stressor was combat-related, evidence of receipt of combat awards or citations such as the Purple Heart or the Combat Infantryman Badge was sufficient supportive evidence of involvement in a stressful situation. We also stated that the inservice stressor need not be documented to an absolute certainty but must be sufficiently supported to permit a reasonable conclusion that the alleged stressful event actually occurred.

On March 26, 1991, we published Interim Issue 21-91-1 to incorporate into the M21-1 Adjudication Manual the above provision concerning evidence of combat-related stressors, which had been inadvertently omitted but which was still in force.

In May 1993, VA published a final rule incorporating into its adjudication regulations portions of the M21-1 Adjudication Manual on PTSD which VA's General Counsel had determined constituted substantive rules promulgated in violation of the requirements of the Administrative Procedures Act. Publication of the final rule corrected that deficiency. The revision included the provision concerning evidence of combat-related stressors but added nothing that had not been in effect in our procedural instructions for the last several years.

Question 77C. If VA is not currently taking any action with respect to these previously denied claims, do you have any plans for initiating such action?

Response. Referring back to the answer to the previous question, we are not aware of any cases that have been adjudicated incorrectly.

Question 77D. How many PTSD claimants, previously denied on the basis of the

Response. application of an invalid directive, have attempted to reopen their claims?

Referring back to the answer to the previous question, we are not aware of any cases that have been adjudicated incorrectly. In addition, our data base would not contain this information.

Question 78. Other decisions of the Court on the issue of PTSD have involved such holdings as the following: (A) continuity of symptomatology is not a requisite for service connection of PTSD; (B) the amount of time between military service and the filling of a PTSD claim is immaterial; (C) opinions of examining psychiatrists, including VA psychiatrists, are not inherently more persuasive than those of other competent mental health professionals; (D) PTSD may be caused by an inservice stressor and exacerbated by a postservice stressor; and (E) alcoholism may be secondary or symptomatic of PTSD. In light of the Court's decisions on these and other issues related to PTSD claims, please describe VBA's efforts to ensure adequate development of claims for service connection of PTSD, including training and instruction of adjudicators on the application of the decisions of the Court.

Response. Rating specialists, hearing officers and adjudicators received training on PTSD and Court-related issues during 14 regional seminars conducted in 1993. On December 6,1993, the Compensation and Pension Service issued a training letter to all ROs regarding PTSD. This training letter included a definition of "stressors." Regional offices were cautioned that full development is necessary on any claim in which stressors are not immediately apparent. This training letter reinforced information provided to ROs during the one day training sessions held at the ROs by Compensation and Pension Service personnel during the last year. In addition, training on PTSD issues is part of the curriculum at the Veterans Benefits Academy for new Rating Specialists.

Question 79. Please give your assessment of the overall training provided at the Veterans Benefits Academy to adjudication personnel on PTSD and the adjudication of PTSD claims.

Response. I believe that PTSD issues are adequately covered as part of the curriculum at the academy. In all of the classes instruction is given by VBA and VHA experts on PTSD.

The training includes major segments on claims processing such as basic rating theory, requirements for establishment of service connection for PTSD, diagnoses and coexistence of PTSD with substance abuse.

Question 80. Are you satisfied that rating specialists are generally provided adequate training and education to enable them to assign fair and accurate ratings for PTSD and other mental health disabilities.

Response. Yes. During the last year we made a concerted effort to focus training on PTSD issues. The formal courses given at the Academy, onsite training seminars with Central Office experts, and detailed training materials give rating specialists and Hearing Officers all they need to adjudicate PTSD and other mental health disability claims. We will continue to provide training on PTSD, and other issues to make sure that our employees have all they need to make informed and fair decisions.

Question 81. Please describe what coordination exists between VHA and VBA in the areas of education and training of adjudicators for the processing of PTSD claims and state whether you believe such efforts are sufficient, and, if not, please describe your plans to increase such efforts.

Response. With VHA's help, we recently made several video tapes to train regional office and medical center personnel. We made tapes on both PTSD and POW claims. All regional offices show these to new rating board members. VHA physicians train new and journeyman rating specialists on PTSD and other health issues during quarterly training at the Veterans Benefits Academy. VHA also helps us to teleconference training on PTSD and other health issues. In addition, input from VHA physicians was used when we prepared the PTSD training letter issued on December 6,1993. This multimedia approach allows us to keep our employees up-to-date on new issues, developments in treatment methods, changes in legislation and decisions by the Court of Veterans' Appeals.

I believe these measures are sufficient, but will evaluate them periodically to assure proper handling of PTSD claims.

Question 82. Please describe the current role of the PTSD Claims Coordinators at regional offices and what indication there has been from the regional offices concerning whether they are consulted sufficiently by adjudicators handling PTSD claims.

Response. Specific duties and responsibilities of the coordinator include thorough familiarity with all guidelines, responding to inquiries concerning adjudication procedures and specific PTSD claims, acting as liaison with medical center personnel, and advising the Adjudication Officer of patterns of deficiency or ongoing problems during the adjudication of PTSD claims. We have no indication that there are insufficient consultations.

Question 83. The VA home loan guaranty program has been utilized by millions of veterans and their families. A new commitment was made to the program in the last Congress by way of fundamental legislative changes enacted in Public Laws 102-54,102-291, and 102-547 under which the Federal Government's long-term support was placed on a regularized, stable basis. What do you see as the primary advantages of VA's loan guaranty benefit for veterans?

Response. The primary advantage of using the loan guaranty benefit continues to be the no downpayment feature. With the current $46,000 maximum guaranty amount, veterans who can qualify can obtain no downpayment VA loans of up to $184,000. Second, the opportunity to offer their homes for sale with assumption of the VA loan is important to veterans. We also help veterans by personally assisting them if they fall behind in their payments. When a delinquency is reported, we contact the veteran, review his or her personal situation and work with the veteran and loan holder to complete the most realistic alternative to foreclosure. In most cases, the veteran is able to make up the delinquency and reinstate his or her loan. If the veteran can resume payments, but the loan holder won't extend further forbearance, we may buy the loan (refund it). If the veteran can't pay for the property, we will encourage him or her to sell it or will accept a deed in lieu of foreclosure.

Question 84. During FY 1993, VA's Home Loan Guaranty Program had its second highest loan volume in more than 30 years—383,303 loans guaranteed. Forty-two percent of those loans were refinancing loans, with more than 87 percent of those loans able to reduce the interest rate. It would appear that these lowered interest rates will make many of those loans more secure and less likely to later default. With the apparent reduction in loan volume—which seems likely this fiscal year—do you see any reduction in personnel to handle the loan volume?

Response. We expect loan volume in FY 1994 to be extremely high, compared to past years. We have already guaranteed approximately 100,000 loans for the first two months of FY 1994. We do estimate that the number of foreclosures will go down, but, as long as the number of new loans remains high, we don't foresee any major reduction in FTE.

Question 85. A report recently issued by the General Accounting Office (Home ownership Appropriations Made to Finance VA's Housing Program May be Overestimated (GAO/RCED-93-1 73, September, 1993)) indicated that VA has had to pay hundreds of millions of dollars in increased costs to cover the subsidy costs. If VA is able to lower its subsidy costs, will that free up any funds and, if so, what will such funds be used for?

Response. GAO's report said we over estimated the number of foreclosures that will occur from loans closed in fiscal years 1992 and 1993. This overestimation, in GAO's view, gave us more subsidy appropriations than we will need to meet future foreclosure costs.

Only a very small amount of the subsidy appropriation has been spent because the bulk of the foreclosures from FY 1992 and 1993 closed loans won't occur until 3 to 6 years down the road. If GAO's estimate is accurate, excess funds will be returned to the Treasury. These funds are not available for any other purpose.

After Loan Guaranty staff made an indepth study of both OMB's and GAO's model, we decided the best course of action was to build a VA model. This model was completed during the summer of 1993. It has been approved by OMB and it was used in preparing the President's FY 1995 budget submission.

Question 86. Do you support a downpayment requirement, in order to secure a VA-guaranteed home loan?

Response. No. The no downpayment feature was designed to assist veterans who, by virtue of their service in the Armed Forces, were unable to save the money needed for a downpayment on a home loan. I believe the lower funding fees charged veterans who make down payments motivates those who can make down payments to do so.

Question 87. Would you favor or oppose restricting loan guaranty entitlement to one-time use?

Response. I personally oppose restricting loan guaranty entitlement to one-time use. Veterans who are forced to purchase a new home due to a relocation of their job assignment or a change in family size may need to use this benefit, just as much as they did the first time. It would also hurt veterans who need to refinance their home loans to withdraw some of the equity for education, medical bills, or other worthy purposes. Recent legislation did establish a higher funding fee for veterans using the program a second or subsequent time. This is equitable since those veterans can still take advantage of the home loan benefit. I do not believe we need to further restrict the reuse of entitlement. Reuse of entitlement helps veterans and their families, and program statistics clearly indicate that veterans reusing the program have a much lower rate of foreclosure (32% lower for FY 1985-1991) than veterans as a whole.

Question 88. Section 8 of Public Law 102-54 allows the Secretary to make loans of up to $4,500 to nonprofit groups who provide transitional housing assistance exclusively to veterans who are in, or who recently have been in, a program for the treatment of substance abuse. Have any loans been made under this authority? Describe what efforts have been made to inform persons about this program and your views on the utilization of the program.

Response. This program is directed by the Veterans Health Administration. Before we can get started, we have to set up a new fiscal system, issue new procedures and get an amendment to the Appropriations Act passed, all issues that have taken a lot of time. We expect to get started about the middle of this year.

We will both notify the veteran community and ask the veteran service organizations, state and local community service offices and nonprofit organizations to encourage applications for loans.

Since the program is a pilot, we can't say how much it will be used, but we project it will be a success.

Question 89A. To the extent that active duty military personnel default on their VA-guaranteed home loans, do you believe that the military departments can help alleviate this problem?

Response. The military departments have goals and functions that are not the same as ours. We believe that using the military as a collections agent for delinquent GI home loans is not appropriate. They are, however, helping us by sharing computerized information which we in turn use to notify military personnel with GI loans about supplemental servicing assistance available through VA.

Question 89B. Do you believe that the military departments should be asked to share the financial burden created when active duty personnel default on their VA guaranteed home loans which are currently absorbed by VA and the servicemember?

Response. The cost of the VA-guaranteed home loan program to the taxpayer remains the same, regardless of whether it is appropriated to the military budget or VA's. Transferring part of the program cost to the military would add to the recordkeeping. In default cases, if the costs arise due to base closures, though, the military can compensate service members for these costs through the Homeowners Assistance Program.

Question 89C. Please answer parts A and B with specific reference to the manufactured housing program and, based on your experience with service personnel use of this benefit, please indicate whether you would favor termination of the VA manufactured housing program and give reasons for your position.

Response. The answers to parts A and B are the same for manufactured homes as for other types of homes.

High foreclosure rates for manufactured home loans adversely affected the financial solvency of the loan guaranty program and resulted in substantial debts against veterans whose loans were liquidated and homes repossessed. The VA Inspector General previously recommended that we propose legislation to eliminate the manufactured home loan program. We submitted a proposal to the 101 st Congress, Second Session, but Congress did not act on it. Rather than resubmit it to the 102nd Congress, we submitted a legislative proposal to require a 10 percent downpayment on manufactured homes. There has been no Congressional action on this proposal.

Use of the manufactured home loan program has diminished in the last two years. Only 67 manufactured home loans were guaranteed in Fiscal Year 1993 and 126 the previous year. Based on the risk of such loans and from a purely administrative standpoint given the few loans being made, it may again be time to consider termination of the manufactured home loan program

I would point out that manufactured homes permanently affixed to real estate perform just as well as conventionally-built homes and should continue to be eligible to serve as security for 30 year, no-downpayment VA guaranteed loans.

Question 90. Do you believe VA takes adequate steps to notify veterans when an individual defaults on a VA-guaranteed loan that the individual assumed from the veteran and on which the veteran remains liable to VA? If not, what additional steps would you take?

Response. We do our best to locate and notify liable veterans about defaults by people who assumed their loans. In addition, we now require the loan holder to make a reasonable effort to locate liable veterans and advise them of loan defaults.

Question 91. As you know, one of the options identified in the letter sent to a veteran following a default on a VA-guaranteed mortgage is that VA will consider refunding (refinancing) of the loan.

(A) How often does the VA refinance mortgages in default?

Response. In FY 1993 VA refunded 1,087 GI loans.

(B) What criteria does VA use in making a decision whether or not to refinance a loan?

Response. Five criteria are used:

1. The loan holder is unwilling to grant further forbearance;

2. The veteran wants to retain and occupy the property;

3. The veteran is able to care for and maintain the property;

4. The veteran is presently or potentially able to resume regular payments within a reasonable period of time and to eventually repay the loan; and,

5. The estimated net value of the property is greater than the unguaranteed portion of the loan.

Question 91C(1). Does VA Central Office monitor and enforce any policy requiring regional offices to consider refinancing loans?

Response. Our instructions require that refunding always be considered as an alternative to foreclosure before a GI loan is terminated. Under our Quality Control Procedures a sample of terminated GI loans is reviewed by each field station each month. This review includes confirmation that a decision concerning refunding is documented and supportable. Central Office Survey staff perform a similar review of a sample of each field station's cases on a periodic basis (every 18-24 months).

Question 91C(2). What evidence is available to demonstrate that VA regional offices are considering and using refinancing as outlined in the default letter for every case?

Response. Each VA loan folder is documented to show that refunding has been considered and that the decision is supportable. In addition, each field station retains the forms that document their Quality Control case reviews, as does the Central Office Survey staff.

Question 91D. In your view, does VA randomly apply the discretionary refinancing option?

Response. Refunding rates vary between field stations. This variation is not, however, random, and should be expected for a number of reasons: some VA offices put greater emphasis on working closely with the veteran and the loan holder to develop repayment plans that facilitate reinstatement of the loan over an extended period of time. For example, of the 15 offices which refunded 5 or fewer loans in FY 1993, eight were highly successful in assisting veterans to avoid foreclosure by intervening with loan holders and making arrangement which resulted in reinstatements. In others, local economic conditions may often prevent a veteran who has lost his or her job from finding new employment at a salary which permits resumption of loan payments, even if the interest rate on the loan can be lowered. In still others, a declining real estate market has reduced home values to the point that the veteran's mortgage is considerably greater than the value of his or her property. These veterans have little or no incentive to continue payments on their loans.

Question 91E(1). Both the Federal Housing Administration (FHA) and the Farmers Home Administration (FmHA) are required to decide affirmatively eligibility for refinancing delinquent loans. Please explain in detail if you support or oppose applying similar eligibility and affirmative decisionmaking requirements to the VA home loan guaranty program.

Response. The FHA assigns eligibility on these criteria: 1) The holder intends to foreclose; 2) At least three installments are due and unpaid; 3) The borrower lives in the property; 4) The default is caused by circumstances beyond the borrower's control; 5) The borrower only owns one property financed through the program; and, 6) There is a reasonable prospect that the borrower will be able to resume full payments within 36 months.

These criteria are essentially the same as ours. The sole exception is the 36 month standard for resumption of payments on the loan. We oppose this standard for refunding in the GI home loan program because it would cause a substantial increase in the number of loans refunded and a consequent sizeable increase in Loan Guaranty program outlays.

As for the Farmers Home Administration guaranteed single family home loan program, we are not aware of a comparable assignment or refunding program.

Question 91E(2). Absent the application of statutory refinancing requirements similar to the FHA and FmHA programs, in your view, are the FHA and FmHA programs superior to VA's with respect to due process?

Response. The FHA assignment program provides the borrower with a formal application procedure and appeal rights if an assignment application is rejected. VA refunding is discretionary and there is neither a formal application procedure nor an appeal procedure. The FHA program therefore provides greater due process to the borrower than the VA program, but this does not make it superior to VA's. When we last compiled comparative data between the VA and FHA programs, VA's foreclosure rate was 12% lower than FHA's. This indicates that veterans are better served under VA procedures than they would be if these procedures were replaced by FHA's.

Currently, in 87 percent of the cases in which banks foreclose on VA guaranteed loans, VA acquires the deed to the property by paying off the mortgage. These properties are placed in the VA's property inventory, where they are maintained and then sold to recoup as much of the VA's investment as possible. One of the ways VA disposes of these properties is by lending money directly to buyers, or "vendee loans." What percentage of vendee loans are subsequently in default and acquired by VA?

The only information available about repurchase rates on vendee loans was developed in 1988. Prior to 1988, VA vendee loans were sold subject to an agreement that they would be repurchased (i.e., "acquired") by VA in the event of serious default. In 1988 we began to sell vendee loans to trusts which issued securities for sale to investors. Loans sold to the trusts are not repurchased by VA. In order to market these securities, it was necessary to show the rate at which vendee loans were repurchased by VA due to defaults and the rate at which these acquired loans were foreclosed. Our research showed that 19% of all sold vendee loans had been reacquired by VA and only 53% of the reacquired loans had to be foreclosed. The others were either reinstated or paid in full.

Question 92B. According to VA home loan quarterly reports on Portfolio Loans in Foreclosure, COIN PLS 29-01, many vendee loans are in default for many months and even years prior to foreclosure.

(1) Why are so many vendee loans delinquent and how does this rate compare with the delinquency rate overall in the home loan guaranty program?

Response. As of September 30,1993, 3.2% of all GI loans were delinquent, while approximately 29% of all vendee accounts in VA's portfolio were delinquent. There are two major reasons for the delinquencies. First, before 1988, almost all vendee loans were sold subject to reacquisition by VA in the event of serious default. As a result, only the problem accounts return to us. Second, because VA obtains the properties that secure vendee loans through GI loan terminations, these properties are often concentrated in areas with economic problems and higher than normal default rates.

(2) What, if anything, do you think should be done to reform this system?

Response. We believe no reforms are needed. As previously noted, the high delinquency rate on vendee loans in our portfolio is largely explained by the fact that we don't buy back loans that are being repaid, just delinquent loans.

Question 92B(3)a. In your view, does VA's present system fail to consider adequately refinancing of VA-guaranteed mortgages?

Response. Refunding is adequately considered by us prior to every GI loan foreclosure.

Question 92B(3)b. Should VA acquire income-generating mortgages from banks by refinancing VA-guaranteed loans, rather than acquiring properties? Please explain your position in detail.

Response. This question cannot be answered as an "either/or" choice. We currently acquire properties after GI loans are terminated through foreclosure or voluntary conveyance. Such loan terminations only occur when there is no realistic alternative. If the veteran is capable of making payments on the loan (i.e., making the mortgage an "income-generator"), the loan is either reinstated before foreclosure or refunded by VA.

Question 92B(4)a. What is VA's pricing policy and is there a maximum percentage over market value at which VA lists portfolio properties for sale?

Response. We list properties for sale at prices that are in line with current market values of similar properties located in the same communities, based on estimates of value provided by private sector appraisers and real estate brokers. While there is no policy to automatically increase (or decrease) values recommended, rapidly changing markets make estimating difficult. Because of the lowest mortgage interest rates in over two decades, the demand for housing in most areas of the country exceeds the supply. As a result, current market values are usually higher than they were 3 to 6 months ago. Consequently, sales prices on VA properties may exceed the list prices that were based on property sales made 3 to 12 months earlier.

Question 92B(4)b. Concerns have been raised that some stations or their affiliated sales brokers fail to disclose property defects to potential buyers prior to the sale, yet the VA policy manual on this point says, "in a proper relationship between the VA and its sales brokers, the purchaser will be informed of such defects." Are you aware of this problem and what actions, if any, are necessary to correct it?

Response. We are not aware of any stations that routinely or intentionally fail to disclose known defects. There are undoubtedly some instances when we

failed to disclose known defects, but these are inadvertent. When we find that we made an error, equitable after-sale adjustments are made. Nevertheless, we are reviewing current policy and procedures to see if improvements can be made.

Question 93A. How do you explain the widely varying amounts of money spent by various stations on maintenance and upkeep of portfolio properties?

Response. Several factors account for the amount of money spent on maintenance and upkeep Of VA acquired properties, including the availability and costs of materials and labor, age of the properties (homes in the parts of the country with older housing stock usually require more in the way of repairs), incidence of vandalism, and local housing code enforcement programs. Even variations which appear to be within VA's control may be affected to a certain extent by local market conditions, because VA field stations often exercise the discretion to improve marketability of properties by putting them in such conditions that they will compare favorably with competitive properties.

Question 93B. Given the wide variations in these amounts, as well as rates Of refinancing and foreclosures, what action is taken to oversee and manage the VA home loan guaranty program for continuity? Beyond sending memoranda of broad guidelines to the field, what does VA Central Office management do to ensure equitable access to veterans benefits, as well as competent execution of VBA policy?

Response. We believe our policies and procedures are comprehensive, as specific as necessary, and, for the most part, consistent. We do give field stations some flexibility in the area of termination of defaulted loans because of variations in State foreclosure laws. Similarly, our property management and disposition procedures allow field stations to adapt their operations to prevailing local real estate market conditions.

Our quality control system requires that field stations review each phase of their operations monthly and report their findings to Central Office. In addition, about once every 18 months a Central Office team makes an onsite visit to review compliance with policies and procedures.

Question 94. An August 2,1993, VA press release announced that veterans are eligible to refinance their VA-guaranteed mortgages at lower market rates. What additional steps has VA taken to encourage veterans to do so?

Response. VA is currently mailing letters to the 2.1 million veterans with VA loans with interest rates of between 8.5 and 17.5 percent. The letter tells veterans how much money they can save by refinancing their VA-guaranteed mortgages at the current lower interest rates, and that the out-of-pocket costs of the refinance can often be included in the new loan. Included in the letter is a toll free telephone number for help in finding a lender who will make these loans without requiring a property appraisal or a credit check. A press release was issued on January 3, 1994, announcing this latest effort, again encouraging veterans to look into the refinancing option. We are also asking veterans service organizations to help us publicize the availability of refinancing loans.

Question 95. VA's vocational rehabilitation program is presently confronted with an increasing caseload and a reduced number of employees in the vocational rehabilitation and counseling division. Please discuss your views on

this situation, and any plans you may have for addressing a growing need for vocational rehabilitation services in such an environment.

Response. The large number of military personnel being separated, combined with the impact of DTAP, have resulted in an increase in requests for all VR&C services. To meet this challenge, we have directed field staff to use contract service providers. We've also modified some procedures that reduced administrative time and increased direct service time. Staff development and training have been emphasized, which should improve the efficiency of services.

Question 96. The administration of the educational assistance program is currently centralized in four different regional areas. In your opinion, has this regionalization been beneficial to the areas of service delivery, effectiveness, and efficiency? Please discuss any future objectives you may have to further enhance these three areas.

Response. Chapter 30, the Montgomery G. I. Bill Active Duty program, is consolidated into four processing sites. This represents almost 60% of all of the education workload. This consolidation allows concentration and specialization in education with a core of trained adjudicators. Quality is better for Chapter 30 and timeliness is also improved. While 72% of all non-Chapter 30 original claims are completed within 30 days, 84% of the Chapter 30 original claims are completed in 30 days or less. The twelve percentage point difference indicates that the four offices process more education claims with fewer personnel. This efficiency is further evidenced by higher productivity in the four sites than the national average. Because of the improved efficiencies realized at the regional processing centers, in July 1993 all non-Chapter 30 education cases in the State of California were consolidated to the San Diego Regional Office. Early indications show that this has resulted in more timely processing of California cases, and we expect further improvements in the coming months. As a result, additional education consolidation efforts are under review.

Question 97A. What is your assessment of the current efforts of VBA concerning the employment of disabled veterans?

Response. The focus of the Chapter 31 program is employment of disabled veterans and, over the last two years, the number of disabled veterans who have been successfully rehabilitated is 18% higher. This equates to a 400 percent increase in the average annual salary for this group of veterans. We concede that there is room for improvement in employment services, but our efforts to enhance the services have intensified. Last August, a one-week employment services training program was conducted for field staff. The VR&C Service has sent numerous job placement reference materials to regional offices and they are assisting regional office staff in the development of regional training programs.

Question 97B. Please describe your plans to further ensure that disabled veterans are affirmatively hired and promoted as required by title 38?

Response. We share responsibility with the Department of Labor for placement of disabled veterans through a cooperative agreement. We have established and will maintain close working relationships locally through veterans employment representatives and the disabled veterans outreach program. We continue to promote the nationwide Job Ready Disabled Veterans

Connection, a program implemented jointly with the Office of Personnel Management. This program refers disabled veterans to Federal agencies that can use noncompetitive hiring authorities. VA also offers on-the-job training programs and unpaid work experiences to help disabled veterans compete in the job market.

Question 98. There have been several serious questions raised by Vice President Gore's National Performance Review concerning the Veterans' Employment and Training Service (VETS), within the Department of Labor. VETS has entered into a period of structural reinvention as a result of these questions. As the Under Secretary for Benefits, what role, if any, do you hope to see VBA play during this phase of reinvention for VETS?

Response. We maintain close liaison with VETS at both a national and local level. We have working agreements in place which ensure that veterans are properly served by our Departments. We see this type of working relationship as critical in the coming years. We believe we will continue to play a role in training VETS staff, referring veterans seeking employment assistance, and assisting veterans referred to us by VETS. We will provide whatever assistance is required during the VETS reinvention effort to help make certain that veterans are well served.

Question 99A. What is your assessment of the effectiveness of the Transition Assistance Program (TAP) in assisting America's servicemembers to make successful transitions back into the civilian workforce?

Response. Outreach to active duty military personnel pending separation has always been one of our priorities. The implementation of TAP expanded what we had been doing previously and linked us with the Departments of Defense and Labor in providing transition assistance to separating military personnel through a structured program. However, our efforts are broader than the Transition Assistance Program alone. We have defined VBA's "Military Services Program" as encompassing several key outreach efforts: TAP, support of the individual service departments' transition management programs, presentations and counseling through separation and retirement briefing programs, special outreach to Reserve and National Guard units, and various other military liaison activities (for example, military education, family services, community services, personal services, and casualty assistance).

We are pleased with the reception that VA representatives have received, both from military installation officials and active duty personnel. We realize, of course, that the effectiveness of a program cannot be measured based on numbers alone. However, in the past two fiscal years, our counselors have participated in more than 13,000 briefing sessions attended by just over 636,000 servicemembers and have also conducted over 231,000 personal counseling, claims assistance, or inquiry resolution interviews.

Question 99B. Please discuss any problem areas you perceive concerning TAP and its administration, and any plans you have for rectifying these problem areas.

Response. While there were some problems in the implementation of the pilot program, both locally and nationally, these were normal startup difficulties involving communications, roles and responsibilities, logistics, scheduling and so forth. Over time, we have worked through these minor difficulties and now have a successful program. However, we are concerned that potential budget

reductions may affect our outreach programs, particularly those for active military personnel pending separation.

We believe that we have a good working relationship with DOD and each of the military services, as well as with DOL at both the national and local level. There is frequent communication between the agencies and problems are usually resolved at the local level.

Question 100. Under Public Law 102-568, the amount of insurance coverage under the Servicemen's Group Life Insurance program was increased from $100,000 to $200,000. As you know, in order to obtain the higher benefits the servicemember had to affirmatively request the increased benefits in writing. Previously, increased coverage was granted unless the servicemember declined it.

Response. If there are attempts in the future to increase the maximum insurance coverage, in your view, should the election of increased coverage be done through a negative enrollment or by specific election to receive increased coverage? Please explain the basis for your views.

I believe that any future coverage increases should be implemented using the negative enrollment approach. Servicemembers could be given a briefing on assessing their insurance needs and options.

I raised this issue with the Department of Defense and the other members of the SGLI Advisory council at our annual meeting. At the meeting, it was suggested that a film be jointly produced to help members decide how much insurance they need, and about the importance of having clear and updated beneficiary designations. I strongly support this idea. Our Insurance staff is working with the Office of Servicemen's Group Life Insurance and DOD to produce the film.

Question 101. Collection of Insurance premiums is both labor intensive and costly. I know there are efforts being made to reduce the labor intensive paper transactions by allowing electronic transfer of funds and other administrative actions. What ways would you suggest to improve the efficiency of this operation while maintaining or improving the quality of services?

Response. When I became Director of the Insurance Service in 1984, the Insurance program was receiving over 11 million remittances each year. In 1993, we received approximately 5.3 million remittances, a reduction of about 53 percent. Although some of that decrease can be attributed to the fact that there are fewer policies in force due to the maturation of the program, the majority were eliminated due to various initiatives over the years. Our latest initiative is Net Premium Billing. We expect it to reduce the total number of remittances by another 12 percent in 1994; the number of policies in force will decrease by only 3.4 percent.

We also took advantage of improved technology by replacing our outmoded remittance processing terminals with new terminals. Because of the improved capability of the new equipment, we were able to reduce the number of terminals and reduce staffing.

We will continue to seek ways to further reduce costs while maintaining or increasing customer service.

Question 102. Under the National Service Life Insurance there is an "H" account which was issued between August 1,1946 and December 31,1949, and provides insurance to certain veterans. This insurance has the same premium rates and policy provisions as "V" insurance except that it is nonparticipating—the policyholders do not have the premiums invested and thereby do not receive dividends. At the present time there are approximately 2,000 living policyholders. Many have complained that the annual premium is very high and that most, if not all have paid premiums that exceed the face value of the insurance. Please indicate what options, if any, may be available to cap premiums for these elderly veterans.

Response. The program in question ("H" insurance) was established as a special subprogram of the regular National Service Life Insurance (NSLI) program to provide a means of issuing coverage for veterans who, because they had incurred service-connected disabilities, could not meet good health requirements for obtaining or reinstating NSLI.

The problem we face in capping premiums is a funding problem. There are no reserves available to support the capping of term premiums, as we were able to do for the NSLI (V) policies. Similarly, there are no surplus funds generated by these policies today that could be used to pay dividends and offset the net cost of the permanent plans. To fully fund the H policies on the same basis as the NSLI (V) policies, we would need about $7,000,000.

We have considered a legislative initiative that would allow us to merge the H policies in with the V policies, but have reservations about the legality of such an initiative. We are exploring alternative solutions.

Question 103. Please provide your views on expanding the payment of plot allowance to states for all veterans buried in state veterans cemeteries.

Response. A bill introduced in the first session of the 103rd Congress essentially would expand eligibility for plot allowance payments to the states by covering the burials of all veterans buried in state veterans cemeteries. We oppose this measure because it would unfairly enlarge a preferred class of veterans simply on the basis of burial location and thereby expand existing entitlement disparities among similarly situated veterans. We also oppose it on "pay-as-you-go" budgetary grounds.

WRITTEN POSTHEARING QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. VOGEL AND THE RESPONSES

Question 1. You will assume the position of Under Secretary for Benefits at an extremely crucial time. Please discuss in detail what you see as the major problems facing VBA, and, if confirmed, what your overall plan will be for addressing these problems and finding solutions.

Response. The biggest problem, of course, is the adjudication backlog. The problem is complicated by increasing workload, and increasing complexity in that workload, at a time of decreasing resources. We are addressing this problem from two directions. First, we are rethinking the approach to structuring and managing adjudication. We are emphasizing an approach which reduces fragmentation and increases the number of staff concerned with the end result rather than a single step. We also are continuing with a heavy emphasis on quality and doing things right the first time. Second, we are now in a

position to modernize ADP support to the adjudication process. This makes it possible for us to shift routine, tedious work from people to computers, giving our staff more time to focus on customer service and decision making. It also helps us to improve quality by using computers to assist in properly dealing with complex rules and rapidly changing regulations—our expert systems and automated access to reference materials are examples of this kind of support. The combination of these two approaches makes it possible for us to do more and better with fewer resources.

Question 2. One of the most serious challenges that you will confront is the threat of significant cuts in staff. This threat exists at a time when VBA likely needs more, not fewer, personnel, and any meaningful reform of the adjudication system might not survive the proposed reductions. How will you handle these reductions if they become a reality?

Response. Reductions in VBA staffing over the next few years may create situations where normal attrition might not provide sufficient staff reductions. In that event, it will be necessary to employ tools such as special placement programs within and outside the Department, voluntary early retirements and buyouts, if available. If necessary, furloughs and reductions in force will be used as a last resort.

Question 3. Your answers to prehearing questions concerning the impact of judicial review reflect the belief that the Court's decisions have led to better VA decisionmaking, and that the Court has been beneficial to veterans. Do you feel that the Court has imposed new requirements on VA, or is it simply applying existing law?

Response. Prior to passage of the Judicial Review Act, review of administrative decisions relating to veterans benefits as well as interpretation of laws relating to veterans benefits was the responsibility of the Department of Veterans Affairs. With the advent of judicial review, the Court of Veterans Appeals now has jurisdiction to review such interpretations. This has led to requirements for more thorough development and comprehensive decisionmaking which, in turn, has resulted in more well reasoned and better supported determinations on veterans' claims. Judicial review has resulted in some Court decisions which apply existing law, thereby providing guidance for VA decisionmakers, and others which clearly place new requirements on VA. For example, new requirements result when the Court invalidates a portion of a VA regulation as in Gregory v. Brown, 5 Vet. App. 108 (1993) and Gardner v. Brown, 5 F.3d 1456 (Fed. Cir. 1993), petition for cert. filed, U.S.L.W. (U.S. Jan. 11, 1994) (No.). After invalidation of a regulation, VA is required to interpret the law in accordance with the direction provided by the Court decision. In most cases, however, the Court has applied existing law to particular factual situations which results in interpretive guidance for VA decisionmakers. Although VA may already be applying the law in accordance with Court guidance in most situations, we assess every Court decision to insure compliance. If we feel further clarification or expansion for our regional offices is warranted, we will effect a change to the Adjudication Procedures Manual (M21-1).

Question 4. In your answers to prehearing question 22, you stated that VA has provided the benefit of the doubt to the claimant all along. However, a number of decisions, such as Dyess v. Derwinski and Townsend v. Derwinski, indicate that VA has not consistently applied this principle. What steps can be

taken to achieve greater success in meeting the goal of giving veteran claimants the benefit of the doubt in all cases?

Response. Instructions have been issued to regional offices in M21-1, Part VI, 17.62 concerning the application of the benefit-of-the-doubt rule. This area has been a subject in all our training sessions provided to rating specialists, Hearing Officers and adjudicators. It will continue to be an area emphasized in future sessions. We will take every opportunity to remind regional office personnel that the benefit-of-the-doubt rule is for consideration whenever there is an approximate balance of positive and negative evidence.

Question 5. It seems clear that there are going to have to be some big changes in the way VA handles claims for benefits. The current backlog is not acceptable to anyone and it is unlikely that there will be an infusion of new funding any time soon.

The following questions address the current operation of regional offices.

A. First, what is the approximate total workforce in the 58 regional offices?

Response. As of the end of December 1993, the workforce in our 58 regional offices was 12,126 people. This does not include the employees in our Insurance Centers, Debt Management Center, Benefits Delivery Centers, or our Area Offices. When these employees are added, we show a total workforce outside of Central Office of 13,596 people.

B. On a daily basis, what is your best estimate of the percentage of an average regional office's staff that is in direct face-to-face contact with veterans or other claimants?

Response. These percentages vary widely from day to day among regional offices and among divisions within each regional office. However, by functional design, it is correct to say that 100 percent of Veterans Services Division (VSD) personnel and Vocational Rehabilitation and Counseling Division (VR&C) personnel have face-to-face contact with veterans and other claimants on a daily basis. Approximately 30 percent of our Loan Guaranty Division (LGY) personnel have such contact. Furthermore, we have on average one Adjudication Hearing Officer per regional office who has face-to-face contact with veterans and other claimants in the conduct of hearings.

C. Of those employees who have such personal contact, what is the breakdown of what they are working on? Is it claims adjudication or providing veterans information about benefits or an update on the status of a benefit claim?

Response. VSD personnel conduct personal and telephone interviews with any veteran or other claimant who comes to or calls the regional office. They also perform outreach services to the homeless, the elderly, Native Americans, and others in VA hospitals, community shelters, military bases, or wherever the need may be. In addition, VSD personnel perform fiduciary and guardianship and educational facility liaison functions which involve interaction with the public. Through these activities, veterans are provided information about benefits and given updates concerning the status of their individual claims.

VR&C personnel meet with veterans and other claimants daily for counseling. These sessions are directly related to benefits authorized under chapters 31, 32, 35, 30, and 15 of title 38, USC, and chapter 106 of title 10,

USC. In addition, VR&C personnel conduct DTAP (Disabled Transition Assistance Program) sessions at military bases.

LGY personnel have daily contact with veterans and other claimants, primarily in the loan service and claims area, as part of the home loan guaranty and administration processes.

The only Adjudication Division personnel who regularly meet veterans and other claimants are the Hearing Officers. Such sessions are prearranged by appointment and the results can have a major impact on the claims outcome.

Question 6. Please outline the process for a benefits claim, using a hypothetical case of a World War II veteran who has never sought service connection but now seeks to have a knee problem service-connected. Please describe the steps that he would go through, beginning with the initial contact at the regional office, through a BVA hearing, noting what opportunities would exist for hearings, both at the RO and the BVA, what his right to representation would be, and what documents VA would create along the way.

Response. Hypothetical case of WWII veteran claiming SC knee problem.

NAME: JOHN VETERAN BRANCH OF SERVICE: ARMY

DATE OF BIRTH: 5/19/21 ENTERED ACTIVE DUTY: 4/10/40

SERV NUMBER: 1234567 DISCHARGED FROM AD: 12/10/43

John Veteran visits the Veterans Services Division (VSD) at the XYZ regional office and talks to a Veterans Benefits Counselor (VBC). He tells the VBC that he is having a knee problem that he believes is related to a similar problem he had in 1941 while in the Army. The VBC assists Mr. Veteran in completing a VA form 21-526, Application for Compensation or Pension, based on the information furnished by the veteran. The VBC may also advise him of additional evidence necessary to complete his claim, i.e. verification of service, service medical records, and current medical evidence defining his knee problem.

The completed and signed application is forwarded to the Adjudication division where a folder is established, if one does not already exist. The claim is initially reviewed for complete application information, basic eligibility to the benefit claimed (in this case compensation), and verification of honorable service. If the claim is submitted by mail, which most are, then this initial review normally leads to more development than a claim that has been submitted in person. A pending issue file is then established in the Benefits Delivery Network (BDN) and initial development for evidence is accomplished, including a request for verification of honorable service and service medical records from the Service Department (National Personnel Records Center in this case), as well as essential evidence the veteran may be able to furnish. Since this is a WWII Army veteran, it is possible that his medical records were involved in the fire at the records center in St. Louis in 1973. Therefore, development may include requesting that he complete NA form 13055 for detailed service information that will assist the Service Department in locating any available medical records.

At this point, the claim is reviewed by a rating technician or rating specialist to determine whether an examination at a VA medical facility should be ordered as well as to request detailed information regarding current treatment.

As a part of this review process, all available evidence, as well as the development actions taken thus far, are checked to ensure that the essential information will be available when a rating decision is made.

Assuming that additional evidence is needed to perfect the claim, a control period (generally 60 or 90 days) is set based on the type of evidence requested. Management review of all pending claims will identify this claim for followup action if the requested evidence is not received within the control period. If necessary evidence has not been received from sources other than the veteran, a second request is initiated. This may be done in writing, by phone, or by FAX. The control period is extended as appropriate for the needed evidence. When requested evidence has not been received from the veteran by the time the rating decision is made, the claim is decided based on all other available evidence.

When all essential information has been received from the Service Department, VA medical facilities, and private hospitals and physicians, the claim is reviewed in detail and a rating decision is prepared to either grant or deny service connection for the knee problem. This decision includes a list of the evidence considered, the facts as presented by the evidence, the reasons and bases for the decision, and the conclusion reached. This information is input into the BDN for award or disallowance of compensation benefits and the veteran is notified of the decision. He is notified in detail, including a list of the evidence considered and the reasons and bases for the decision, as well as the conclusion reached. Full information about procedural and appeal rights is included in or attached to the notification letter. At this point, Mr. Veteran has the right to appeal the decision, the right to request a hearing before an Adjudication Hearing Officer to present evidence, the right to be represented by a veterans' service organization, an attorney, or an agent. In fact, the right to representation is present from the very outset of the claim, and the veteran may have the assistance of a service organization representative throughout the whole claims process if he so chooses.

If, within one year after the date of this notification letter, the veteran informs the regional office that he disagrees with any part of the decision on his claim, an appeal is initiated based on his statement of disagreement. When the office receives his Notice of Disagreement, a Statement of the Case is prepared outlining each step in the claims process up to and including the decision on the claim. The veteran is allowed 60 days (or more if an extension is requested) to file his Substantive Appeal (VA form 9) showing why he disagrees with the decision and/or why he feels the VA decision is incorrect. This form affords him an opportunity to request a hearing before the Board of Veterans' Appeals (BVA)? Mr. Veteran continues to have the right to a hearing before a Hearing Officer. If he is not satisfied with the Hearing Officer's decision, he can still request a hearing before the BVA. If a BVA hearing is requested, the case may be placed on the docket for a Travel Board hearing or for a hearing before the BVA in Washington. In any case, the appeal is reviewed by a rating specialist to ensure no further action or evidence is necessary before the hearing is held or before the case is transferred to BVA.

Question 7. It seems that one way to encourage individual regional offices to try new approaches to claims adjudication would be to give more resources to those that succeed in improving their productivity. In this time of scarce resources, is VBA able to do this, or do you find you have to direct resources

to those regional offices that are not doing as well and thus are falling further and further behind?

Response. The appropriate utilization of resources is a topic of ongoing discussion at all management levels. The manner in which the question is posed presents an interesting dilemma. It suggests that those offices that improve their productivity could be rewarded with additional staffing. However, since these resources are finite, the reallocation of resources from one station to another might have a deleterious effect on the service provided no matter what the intent.

Question 8. It seems that there must be various measures by which to evaluate a regional office and its top management—such as progress in resolving claims in a timely manner and reducing existing backlogs or by issuing final decisions in claims that either are not appealed or, if appealed, are affirmed by the VBA. What system is in place now within VBA for rewarding managers who are successful in these areas and for not rewarding those who are not successful.

Response. Both organizational effectiveness and individual performance achievements are considered in evaluating performance of a regional office and its top management. Measurable objectives concerning the quality and timeliness of claims processing are among the many standards which provide the basis for these evaluations.

Assessment of individual performance by top management is completed under VA's appraisal system for Senior Executive Service (SES) employees. Evaluation of other top management staff is completed through VA's Performance Management System. Performance plans, although individual in nature, are tailored to specific organizational objectives. The discretionary nature of the performance appraisal systems permits recognition of individuals who have made a positive commitment to increasing organizational effectiveness in those instances where organizational goals have not been fully attained.

Overall field station performance is reviewed by subject matter experts selected from VACO and field facilities. Results of the review are compared with established standards and action plans are developed to remedy any problems isolated during the review.

Question 9. In your response to prehearing question 17D, you stated, "The culture of the organization has shifted to a focus on quality and timely service to our customers, with genuine concern evidenced for both internal and external customers." Can you explain in more detail how the culture has truly shifted in this way?

Response. Strong direction for this cultural change has come from the top. The stated VBA Mission is "to provide benefits and services to veterans and their families in an effective, timely, and compassionate manner." Several National Performance Review initiatives will also augment this cultural change. In the coming months, the VA will put performance agreements in place between the Secretary of Veterans Affairs and the President. These agreements will stress VA's mission to become the most service-oriented of all Cabinet Departments. In addition, VBA will be responsible for meeting the requirements of Executive Order 12862, "Setting Customer Service Standards." Under this Executive Order, VBA will determine who its customers are, survey

customers to determine the kind and quality of services they want, and post service standards and measure results against them, and survey frontline employees on barriers to, and ideas for, matching the best in business. Due to VBA's proactive approach toward improving customer service, many of these efforts have already begun. On a local level, regional offices have been extremely active in conducting focus groups with customers in order to redesign forms, discover ways to improve communication with our customers, and streamline processes with the customer in mind. To the degree that true cultural change comes from having the information and skills to truly understand the customer, VBA is well on its way to delivering improved service.

Question 10. There has long been a belief by many that VA's work measurement standards lead to poor decisionmaking in the interest of higher productivity. How has VA changed its standards to reflect the shift in culture you described? In your answer, please explain specifically VBA's current productivity standards for adjudication personnel.

Response. First let me address the question's assumption that there is a close tie between the work measurement standards by which we monitor the performance of individual adjudication divisions and the performance standards by which individual decisionmakers are held accountable for their work efforts.

When we look at the performance of divisions, the volume of work is so large that average processing times, statistical analyses of quality indicators, and productivity data have significantly different meaning from any one individual's work efforts. In looking at division performance indicators we get a sense of the efficiency of the overall claims adjudication process. As we have said in the past, decisionmakers' performance standards normally include both quality and timeliness factors as critical performance elements. Therefore, if an individual decisionmaker chooses to sacrifice the quality of his/her work to increase daily output, then he/she also runs the risk of failing that critical quality element.

Currently, the performance standards for most decisionmakers include a production element—often expressed as cases per day. A number of divisions have developed or are developing performance standards for decisionmakers that eliminate the production element entirely in favor of quality and/or timeliness. The divisions in New York and Jackson are in the forefront of this transition.

Question 11. In your response to question 42, you stated that VBA encourages regional offices to monitor appeals remanded from BVA for patterns of inadequate development. How does VBA keep track of what all the regional offices are doing in this regard and compare the kinds of patterns found?

Response. At our monthly conference calls, regional offices provide us with feedback regarding many issues, to include BVA remands. Indeed, because of the calls received from field offices and comments made at the monthly conference calls, we have conducted two studies of BVA remanded appeals. Further, we prepare semi-annual analyses of each adjudication division's operations, to include a review of the processing timeliness of appeals. Our onsite surveys of C&P operations at regional offices provide us with another

opportunity to review appeals processing timeliness as well as discuss areas of program concern with local managers.

Question 12. In your response to question 31B you stated, "[W]e have no reports identifying individual issues in a claim." In your answer to question 42, you provided a chart that included statistics for "appealable issues filed at ROs." Are the "issues" as referred to in question 42 "claims" or not?

Response. As noted in the answers to questions 31A and 31B, some of the traditional adjudication terms are used interchangeably. This is what led to the answers to questions 31B and 42. A "claim" or "case" can be limited to one issue—e.g., service connection for a back condition—or can involve multiple issues—the back plus others. The "claim" is treated as a single entity, and all the issues are enveloped into it. In the answer to question 42, we cited appealable "issues," when in fact we meant appeal able "claims" or "cases." A specific "claim" or "case" might have just one issue on appeal or multiple issues, depending upon what the claimant disagreed with.

Question 13. How did VBA measure the fiscal year 1993 "success rate" in "decision accuracy" referred to in your response to question 47, which you indicated was 96.5 percent. Are reversals by the Board and the Court figured into the calculation, or does this error rate mean that VBA has some internal screening process that found 3.5 percent of the RO decisions to be incorrect?

Response. During fiscal 1993, the Compensation and Pension Service reviewed 5530 randomly selected cases from all Adjudication divisions for accuracy under the Quality Assurance (QA) program. Data from the QA review is used to compute National Accuracy Rates. Decision accuracy, as part of the National Accuracy Rate, was 96.5%. Decision Accuracy refers to one of the three primary review areas that view quality from the customer's perspective: the other two are control/development and notification. Decisions include the complete range of considerations from burial awards through disability rating decisions. These differing types of considerations reflect our responsibility to make accurate determinations. Examples of decision elements for consideration include the erroneous denial of service connection or perhaps the erroneous grant of service connection.

Grants of benefits sought on appeal before the Board of Veterans Appeals or before the Court of Veterans Appeals are not figured into the calculation because they do not meet the statistical random nature of the QA review. However, included in the issues subject to QA review are all Statements of the Case issued on appeals and all Adjudication Hearing Officer decisions.

Question 14. Do you anticipate that the new "Advanced Docketing" of appeals to the BVA will have any adverse impact on the regional offices and the adjudication system?

Response. We anticipate no adverse impact on the regional offices and the adjudication process.

Question 15. You indicated in your responses to the prehearing questions that some of the pilot programs at regional offices have met with initial success.

A. Which of these are you most excited about? Please be specific.

B. How long will you monitor these pilot programs before trying them elsewhere?

Response. Pilot programs serve the organization through their examination and proposed redesign of processes to achieve increases in efficiency, effectiveness and improvements in customer service. These outcomes are critical to VBA's successful operation, therefore, we take great interest in the pilot projects and their efforts to improve service delivery.

The letter writing project, "Writing for Real People", addresses the quality of communications with veterans and their families by writing letters that are easily understood, clear and concise. In an effort to improve timeliness and the quality of the adjudication process, several projects are being tested, including the combination of Veterans Benefits Counselor and Veterans Claims Examiner positions, implementation of self directed work teams and case manager approaches, and the establishment of Rating Board technicians. The objective is to improve claims processing and service delivery by injecting more decision makers into the process and providing more personalized, accessible service.

VBA's Blue Ribbon Panel has prepared an action plan outlining a variety of initiatives that also target the claims process. Composition of the Panel included members from Central Office programs and Regional Office staff as well as participants from veterans service organizations, thus drawing from a wide variety of perspectives and experience. A primary component of the Blue Ribbon Panel's proposal was the utilization of current technological advances. With VBA Modernization underway, several projects will be implemented to assist in claims processing, thereby improving service delivery. These projects include: CD-ROM Retrieval System, COVERS Files Management System, Word Assisted Ratings System and Claims Processing System.

At this time we have not completed full evaluations of all the pilot programs currently being tested at the regional offices. If these pilot initiatives prove to be successful in a variety of regional office environments, they will be made available for use nationwide.

Question 16. The recommendations presented in the report of the Blue Ribbon Panel are substantial.

A. If confirmed, which are your priorities for implementation?

Response. We believe that all the recommendations and the whole action plan are needed, so we are reticent to establish priorities that could be detrimental to the goal. The Panel felt that all were necessary and all would contribute to improving claims processing.

B. In reality, would it not be safe to assume that the initiatives contained in the recommendations of the Blue Ribbon Panel, the National Performance Review, your reengineering, and other efforts, will cost money and actually increase the number of personnel you require? Or at the very least, will they not raise the number of higher status jobs and increase the need for funding for staff?

Response. From its very beginnings, the Panel recognized the reality of the limited nature of resources. Thus, with few exceptions, the Panel's recommendations can be accomplished with existing or expected resources. Those involving the development of sophisticated training technology, such as videoconferencing and the use of satellite transmission, and a complete review

of C&P regulations and manuals, will require additional funding, but the amount has not yet been determined.

Question 17. One source of problems with claims adjudications through the years has been the C&P exam, both in terms of scheduling and adequacy for adjudication purposes. There have been a couple of proposed changes to address these problems.

A. Please provide your views on allowing the use of a private physician's examination report in lieu of the requirement for a VA examination

Response. We have prepared a proposed amendment to VA regulation 38 CFR 3.326, which would allow private physicians' reports to be used for rating purposes in claims for increased compensation involving disabilities that have already been determined service connected. The proposal was published in the Federal Register on February 2.

B. How do you react to the suggestion that C&P exams be done in regional offices and by VBA employees? In other words, the examiners would be VBA employees who would be stationed in the regional offices.

Response. The ongoing concerns about the adequacy of completed examinations is a topic of mutual corrective effort between VHA and VBA. As one avenue to improve the examination report findings, the Physician's Guide for Disability Evaluation Examinations is being made a part of the AMIE system so that examiners will have the criteria relevant to the conditions being examined immediately accessible for their reference. This will significantly improve the quality of the findings they provide to our rating boards. As a second avenue—following one of the Blue Ribbon Panel's recommendations—we will seek to expand the memorandum of understanding between VHA and VBA to include a quality requirement along with the timeliness element.

Question 18. Health care reform will have some impact on the adjudication system, particularly if service connected status affords veterans a priority for medical care. What, specifically, is VBA doing to anticipate the impact of health care reform?

Response. The Department is developing an implementation plan, including scenarios for the operation of VA Health Plans, and VBA is actively participating in this effort. In addition, our efforts in planning, modernization, training, customer service measurement, and reengineering, as described elsewhere in our responses, will equip VBA to provide continuously improving service, and assist in managing and measuring the impact of changes resulting from reform in health care delivery.

Question 19. You indicated that you know of many opportunities for collaboration between VBA and VHA. Please explain how you intend to realize the existing potential.

Response. Our Automated Medical Information Exchange (AMIE) project started us on a highly successful collaboration with VHA. We are continuing joint efforts in information systems development, data sharing and functional improvement in the conduct of medical examinations for compensation and pension claims. Both information systems and regional office staffs meet regularly to review procedures and determine how to improve. Once we complete the installation of Stage I of Modernization at our regional offices,

we will have a technical infrastructure which makes further improvement feasible.

Question 20. In order to help clarify the issues surrounding claims for service connection based on exposure to environmental hazards in the Persian Gulf, please answer the following questions.

A. Do I understand correctly from your response to question 71C that the main reason many Persian Gulf War veterans are not being granted service connection for their illnesses is because their claims are based only on exposure and do not specify a disability?

B. Do these veterans allege disabling medical symptoms?

C. Does this mean that there currently are Persian Gulf veterans with health problems traceable to service who are not being compensated?

Responses.

A—Yes. The primary reason service connection is not granted is no residuals are found on examination.

B—No.

C—No.

Question 21. What information is being provided in the weeks prior to discharge to service members who served in the Persian Gulf?

Response. Regular active duty military personnel who served during the Gulf War are seen in formal Transition Assistance Program (TAP) seminars and other types of preseparation or preretirement briefings generally within 90 days of separation. Through a formal agreement with the Department of Defense, VBA now has six counselors at five locations in Europe. These counselors are on 6-month TDY assignments to provide briefings to transitioning servicemembers stationed there. We are also conducting periodic visits to military installations in the Far East, Cuba and Panama to conduct briefings on VA benefits and services. In addition, the American Forces Information Service has produced 30 and 60 second spot announcements on VA benefits that are distributed and aired on the Armed Forces Radio and Television Service overseas.

As many Persian Gulf veterans were members of the Reserve and National Guard, outreach efforts to these groups were increased during demobilization. We continue to provide briefings to Reserve and National Guard units.

VBA has provided a video on VA benefits and services and other informational tools on benefits programs for use by military installation officials in those instances where a Military Services Coordinator or Veterans Benefits Counselor may not be available to participate in a briefing. The nationwide toll free telephone number is advertised widely at all military installations through displays and handouts.

Military Services Coordinators and Veterans Benefits Counselors provide away-from-office counseling to assist individual servicemembers with their VA benefits. In the past two fiscal years, Military Services Coordinators and Veterans Benefits Counselors have participated in more than 13,000 briefing sessions attended by over 635,000 servicemembers. More than 230,000 personal interviews have been conducted with separating servicemembers.

Question 22. What data has VBA collected regarding the illnesses being experienced by Persian Gulf War veterans? For example, what is the incidence of respiratory diseases and cancer among Persian Gulf veterans?

Response. Some data relating to Persian Gulf War (PGW) veterans' illnesses is maintained by the Louisville Regional Office, where we have centralized adjudication of PGW claims based on exposure to environmental agents. An ad hoc report produced on January 12, 1994, showed the following:

163 cases in which service connection had been granted for conditions alleged to be related to environmental exposure.

77 disabilities were service-connected respiratory conditions (42.5 percent of disabilities;

We are aware of 4 service-connected cancer cases.

We also maintain certain statistics produced from our C&P master records. These records show that, as of December 16, 1993, there were 8159 PGW veterans receiving compensation for 21,810 disabilities. Of these disabilities, 1155 were respiratory conditions. We do not have a figure for the number of cancer cases since statistics are maintained by affected body system rather than type of disease.

Question 23. How many Persian Gulf veterans have died since returning from the Gulf?

Response. While an exact count of deaths is not available, actuarial estimates show approximately 2,441 deaths to veterans who served during the Persian Gulf War, for the period August 2, 1990 through July 1, 1993, regardless of location of military service. These estimated deaths include those of veterans of earlier war periods who served in the active reserves during the Persian Gulf War.

Question 24. How many survivors of Persian Gulf veterans are receiving death benefits?

Response. Our most recent report shows that 129 beneficiaries are receiving dependency and indemnity compensation for the service-connected death of the veteran, and 31 beneficiaries are receiving death pension following the nonservice-connected death of the veteran.

Question 25. Within VA, which entity is responsible for compiling statistics on the illnesses that are being claimed by Persian Gulf veterans and the conditions that are being compensated.?

Response. VBA's Compensation and Pension Service and the Louisville Regional Office both are maintaining statistics. The statistics maintained by the Compensation and Pension Service are compiled from the C&P master records by our Benefits Delivery Center in Hines, Illinois. VHA also maintains statistics from the treatment side through the Persian Gulf Registry.

Question 26. What effort is VBA making in the area of outreach to Persian Gulf veterans to let them know what services and benefits might be available to them?

Response. Outreach efforts continue for veterans who served in the Persian Gulf:

- Veterans Services Division personnel provide briefings and individual counseling for members of the Reserve and National Guard.
- Recently separated veterans also receive information on VA benefits and services through the Veterans Assistance Discharge System (VADS).
- News releases and public service announcements are distributed to advise veterans of their benefits and to encourage them to contact their respective regional office.
- Many of our stations are involved in town meetings and special meetings of Persian Gulf veterans and their families to provide benefits information and respond to inquiries related to problems being experienced by these veterans.
- Our field station personnel are also participating in Congressional field hearings on issues related to Persian Gulf veterans.

Question 27. Of those Persian Gulf Veterans filing claims for benefits, what percentage are unemployed?

Response. VBA does not have unemployment figures for Persian Gulf veterans. However, the Department of Labor has information showing that participants in Transition Assistance Program (TAP) seminars are employed 3 weeks sooner than veterans who did not participate.

Question 28. What is the average age and educational level of those Persian Gulf veterans filing claims?

Response. The average age of Persian Gulf Era veterans receiving VA benefits as of July 1, 1993, was 28.78. VA does not have statistics available on the educational level of these veterans. However, based on our experience, we believe that today's servicemember leaves military service with a higher level of technical skill which should improve vocational placement. A very small number of new veterans are educationally disadvantaged (without a high school diploma) as compared with the Vietnam era where 20 to 30 percent were in that category.

Question 29. What effort is VBA making to provide vocational rehabilitation and counseling services to those Persian Gulf veterans who need such assistance?

Response. As a result of the Disabled Transition Assistance Program (DTAP), Persian Gulf veterans have access to Vocational Rehabilitation and Counseling information and services to a far greater degree than previous wartime veterans. Since DTAP is currently provided at over 200 military facilities nationwide, Persian Gulf veterans can make application to enter the vocational rehabilitation program prior to separating from service, thereby ensuring a faster processing time.

Question 30. In response to question 95 concerning vocational rehabilitation, you indicated that VBA has directed personnel in the field to contract for vocational rehabilitation and counseling services outside of VA. To what extent have field offices used contract service providers, and have there been any problems with this procedure?

Response. Our efforts to improve the timeliness of benefit delivery through the increased use of contracting for services have been successful. Between FY

1992 and FY 1993, the number of veterans and servicepersons who received educational/vocational counseling by contractors increased 160 percent. The use of contracting to provide evaluation and employment services has also increased during the same period.

We have found that contractors can assist in the management of our increasing workload, but proper contract administration and monitoring the quality of contractor services are needed.

Question 31. Please elaborate on your response to prehearing question 99B concerning the Transition Assistance Program (TAP) by answering the following questions.

A. What are the potential budget reductions that concern you, and which outreach programs may be affected by such reductions?

Response. Outreach is always a balancing act. We must apply the resources available at the time to the greatest immediate priority. What we do in terms of outreach—targeted groups and volume—is very much a matter of prioritization at the local level and is determined by resources locally available. At one station, the outreach priority may be Native Americans, in another it may be the homeless. On a national level, all areas, particularly our priority areas, are impacted.

B. How much funding will VA need to keep TAP resources in line with the demands?

Response. In FY 1993, VBA used 111 FTEE in support of TAP and DTAP. Due to resource reductions, we project the number will drop to 75 in FY 1994, and to approximately 42 in FY 1995.

To provide a basic level of service, we would require approximately 38 additional FTEE; an optimal level of service would require approximately 50 additional FTEE. Travel funds would be required in support of the additional staff.

Question 32. In Combee, the Court stated that its holding did not "completely foreclose a radiation-exposed veteran from establishing service connection on a direct basis. Rather the veteran must demonstrate that the disability was related to active service, i.e. incurred in or aggravated during the period of active service—without regard to the alleged radiation exposure." Although I was not in the Senate at the time Public Law 98-542 was enacted, I am satisfied that Congress did not intend the result reflected in the Court's decision.

A. Why would the Combee holding not apply in the case of other presumptions, such as those afforded to veterans exposed to Agent Orange in Vietnam?

Response. The precedential value of Combee is limited to radiation issues, and does not apply to any presumptions which were not expressly addressed in the decision. 38 U.S.C. § 1112(c) does not preclude direct service connection, and in that sense the decision conveys no implication that statutory presumptions limit direct service connection.

38 CFR § 3.311b establishes uniform criteria for direct service connection based on radiation exposure, and the Court has upheld the VA view that there is no other regulation by which direct service connection may be established

based on such exposure. Since VA may allow service connection without regard to radiation exposure under any applicable regulation, the *Combee* decision would not foreclose full consideration of any claim which was based on Agent Orange exposure.

B. If Congress requires VA to establish a process for certain compensation claims, are you personally satisfied that this should preclude entirely the opportunity for proving direct service connection based on the causal factor involved—radiation exposure in Combee—under section 1110 of title 38?

Response. Since the Court has upheld the validity of 38 CFR § 3.311b, I am satisfied that our regulation fully and correctly implements the intent of Congress as expressed in Public Law 98-542.

C. If so, why do you hold this view?

Response. We do not hold the view that a veteran is precluded from establishing a direct causal connection to service when Congress requires that VA establish a process for certain compensation claims. However, veterans may not invoke other regulations to establish causation if exclusive regulatory provisions have been prescribed for specific claims.

Question 33. Concerning the Gardner case, you indicated that VA will continue the moratorium on denials of claims under section 1151. This would indicate that VBA is adjudicating all such claims and granting service connection in cases that would have succeeded under the regulations reviewed in *Gardner*. That does not seem to square with what the Committee has heard from veterans with pending section 1151 claims who seem to understand that all adjudication on these claims has been suspended. Since the original decision of the Court of Veterans Appeals in Gardner how many claims for service connection has VA granted under section 1151?

Response. An interim instruction letter was issued to all regional offices on December 2, 1991, stating that any claim under 38 U.S.C. § 1151 may be adjudicated if a favorable resolution could be made under the current provisions of 38 CFR § 3.358. If the benefit sought could not be granted under the current provisions, then action on the claim was to be suspended and the case listed on a register for control purposes. These instructions to adjudicate claims that can be favorably resolved under section 1151 have been reiterated on several occasions during the past two years. Most recently, the instructions were repeated during our September 2, 1993 and October 7, 1993 Judicial Review Conference Calls as well as in our last letter of January 13, 1994 (copy attached, below) concerning status of the Gardner appeal. The subject will also be covered in future conference calls.

Unfortunately, our data base does not contain information which would enable us to differentiate claims allowed under section 1151 from other allowed claims.

January 13, 1994
Director (00/21)
VA Regional Office 212B (4-6)
SUBJ: Further Instructions Regarding Processing of 38 U.S.C. 1151 Cases

1. In the case of *Gardner v. Brown*, 5 F.3d 1456 (Fed. Cir. 1993), *petition for cert. filed*, __ U.S.L.W. (U.S. Jan. 11, 1994) (No.), the United States Court of Appeals for the Federal Circuit affirmed the decision of the United States Court of Veterans Appeals. The Government is seeking further review

of this decision. A petition for a writ of certiorari was filed at the Supreme Court on January 11, 1994.

2. The suspension of action on all claims involving a denial of compensation under 38 CFR § 3.358 will not be lifted at this time. Continue to maintain a register of cases for control purposes. If a favorable resolution of the claim may be made under the current provisions of 38 CFR § 3.358, the claim may be adjudicated.

3. If you have additional questions concerning the *Gardner* case, please contact the Judicial Review Staff via the WANG mailbox, MAIL VBA 21, JUD REVIEW.

4.Because of the lengthy process involved in litigation, no rescission date for this letter is being provided at this time.

/s/
J.Gary Hickman, Director
Compensation and Pension Service

Question 34. I was pleased to read of the many efforts within VBA related to assisting homeless veterans. Do you have any information on the numbers of currently or formerly homeless veterans who are receiving benefits today—such as compensation or pension—as a result of that outreach?

Response. VBA does not maintain statistics on the number of claims filed by homeless veterans or the ratio of homeless veterans' claims awarded or denied. Staff at VBA regional offices maintain statistics on the number of homeless shelters and community agencies contacted; the number of homeless veterans assisted; the number of homeless veterans referred to VA's Health Care for Homeless Veterans Programs; and the number of homeless veterans referred to the Department of Labor's Veteran Reintegration Project programs.

The success of our outreach initiatives should not be measured by the quantity of VA claims awarded or the number of applications filed. A substantial portion of our outreach efforts for homeless veterans is not synchronized with the processing of claims or the delivery of benefits.

VBA homeless coordinators and veterans benefits counselors work closely with local communities to ensure that homeless veterans are provided access to available VA and non-VA resources. These services and programs include employment assistance, substance abuse treatment, and access to food and clothing. Our attempts are geared to bringing a resolution to homelessness.

VA programs that would greatly benefit the homeless veterans aren't necessarily available to them. For example, eligibility for pension, which is viewed as a critical program, is based upon a medical evaluation of total disability and the requirement that the veteran have wartime service—criteria that homeless veterans frequently do not meet.

Question 35. Please elaborate on your answer to question 91 by providing answers to the following questions concerning VA refunding of a guaranteed loan after default.

A. You stated that in fiscal year 1993, VA refunded 1,087 loans. What percentage of defaulted loans does that represent?

Response. This represents 3.77% of loan defaults.

B. In deciding whether VA will refund a loan, how does VA determine whether a veteran will be able to resume payments within a "reasonable period" and what is a "reasonable period"?

Response. VA refunding guidelines do not specifically define what constitutes evidence that a veteran has the ability to resume mortgage payments or what constitutes a "reasonable period" of time to be allowed before a veteran is expected to do so. Each veteran's situation is unique and each case is reviewed on an individual basis. In this review, judgments as to what constitutes acceptable evidence of the ability to resume payments, what constitutes a "reasonable period" and how much weight should be given these items in the decision to refund, are made by the Loan Service Representative based on his or her experience.

C. You stated that a sample of terminated loans is reviewed monthly by each station. What percentage of terminated loans are sampled under this procedure, and what percentage of sampled cases are challenged by the reviewers?

Response. Our information system does not report or provide a method to compile the percentage of cases that are actually reviewed. Field stations maintain control registers for various Loan Guaranty quality criteria. Register sizes are based on the projected monthly volume of activity at the beginning of each fiscal year and updated with significant changes in workload. For terminated loans the percentage of cases reviewed can range from 2% at high volume stations to 100% at very low volume stations.

In the review process, a number of separate questions are asked with respect to each case. The terminated GI loan review schedule contains a total of eleven questions, only one of which pertains to refunding. An exception can be taken to any one or more than one of these questions by the reviewer. We do not, however, have any data readily available on the percentage of cases reviewed which are so challenged.

Question 36. Throughout your responses to the prehearing questions, as well as at your confirmation hearing, you stressed the importance of training in VBA's current efforts to improve the adjudication system. How is this reflected in the fiscal year 1995 budget?

Response. Training VBA personnel will remain a top priority in 1995, especially in the adjudication activity, and funding is being requested in the 1995 budget for that purpose. We also plan to explore new technologies to develop the most efficient and effective means of delivering instruction to employees throughout VBA's network of regional offices and centers. In addition, we will conduct curriculum reviews and evaluations to ensure that existing courses of instruction are meeting acceptable training standards.

WRITTEN QUESTIONS FROM SENATOR DASCHLE TO MR. VOGEL AND THE RESPONSES

Question 1. During your tenure as Chief Benefits Director, the VA was involved in litigation brought against it by the National Association of Radiation Survivors. The court in this case found that officials within your division had destroyed potentially discoverable documents and had otherwise failed to cooperate in the discovery process. Further, it is my understanding that the court found the VA's "overall failure to comply with discovery requests was intentional or reckless."

In response to a prehearing question regarding this litigation, you stated that the VA "has tried to build on the lessons of that experience" and that the agency's intention is "to assure absolute integrity in the claims process. Please outline what specific steps have been taken by the VA to ensure prompt and accurate delivery of all records sought by litigants, and indicate whether you believe the steps which have been taken are adequate. If you feel that additional steps are required, what are they, and what will you do if confirmed to see that these measures are adopted?

Response. The experience of NARS litigation and other requests for information through discovery demonstrates the need for maintenance and security of any documents or files which may be pertinent to pending or potential litigation. Our records management system is designed to ensure that those documents are appropriately maintained for reasonable periods of time. Likewise, our work with the Court of Veterans Appeals and our own General Counsel during the past few years has helped us to be more attuned to the overall relationship between our offices and the judicial system and the requirements of any discovery process. Each of our program services is administratively positioned to respond to requests for information required in any portion of the legal process—to the extent such information is available and appropriate for release.

I believe the steps we have taken, the technical awareness of our staff, and the overall ability of our organization to be responsive in these situations is adequate and reasonably assures we will respond appropriately to the courts and/or litigants should that need arise.

Question 2. In the January 4, 1994, notice in the Federal Register, Secretary Brown announced that a presumption of service connection based on exposure to Agent Orange and other herbicides was not warranted for prostate cancer. The National Academy of Sciences report, which was based on consultation with outside experts and an exhaustive review of over 6,000 abstracts of scientific and medical articles, determined that there was limited/suggestive evidence of an association between exposure to herbicides and prostate cancer. This same conclusion was reached with respect to both multiple myeloma and respiratory cancers. However, for these two conditions, the VA has determined that a presumption of service connection is warranted.

I am concerned about the inconsistent treatment of the conditions listed as possibly associated to herbicide exposure, and do not see that there is any medical or scientific explanation for providing compensation for two of the conditions, yet denying compensation for the third. Also, it appears that much weight was placed on the fact that the evidence which specifically showed an association between exposure to herbicides and the incidence of prostate cancer is more recent than that showing no association.

(a) Please provide a more detailed explanation than that included in the January 4 notice as to the exact weighing of the scientific evidence on both sides of the issue and specify the exact reasons why a finding against presumptive service connection was reached.

(b) If confirmed, would you order a reexamination of this finding, rather than wait an additional two years until the next NAS report is released?

Response. Public Law 102-4 requires that the Secretary establish a presumption of service connection for a particular disease when the credible

evidence for an association of that disease with herbicide exposure equals or outweighs the credible evidence against an association. A number of statistically significant occupational studies show no association between prostate cancer and herbicide exposure. Although other occupational studies have shown a slightly elevated risk for prostate cancer among farm and forestry workers, only one, concerning a small subset of farm workers, associated the increased risk with herbicide exposure. This one study was published in 1993. Since this study is so recent, we are unable to determine at this time whether its results will be replicated by further research. The Secretary determined, therefore, that the credible evidence against an association outweighs the credible evidence in favor of an association.

The evidence on multiple myeloma and respiratory cancers led us to different conclusions. Most of the studies of multiple myeloma showed an increased risk, though not a statistically significant increase. Two studies, however, do show an association to herbicide exposure. Moreover, since multiple myeloma is closely related biologically to S-cell non-Hodgkin's lymphoma (NHL), this added additional weight to the association between multiple myeloma and herbicide exposure. In considering respiratory cancers, the studies reviewed demonstrate high relative risks in production workers, and one study shows an increased risk with the duration of exposure. Although some studies had not fully controlled for or evaluated smoking, it is unlikely that smoking patterns would vary significantly.

The Secretary has already specifically asked that the National Academy of Sciences conduct further research on the association of prostate cancer with herbicide research. I fully support his request.

Question 3. As you may know, I have long supported providing flight training as an educational benefit to all eligible veterans. A temporary flight training assistance program was established by Public Law 101-237 for those who entered the service after June 30, 1985. This program was later expanded to include those who entered the service after December 31, 1976.

This program is scheduled to expire at the end of FY94. I intend to introduce—and push vigorously for—legislation which will make permanent this benefit. Given my interest in this issue, I would very much appreciate your response to the following questions:

(a) Do you support the availability of flight training benefits for eligible veterans? Please explain.

Response. A recent study done for VA by Booz-Allen & Hamilton, Inc. shows that a large number of veterans who have participated in the flight training program have been successful in obtaining employment in the aviation field. The study is currently pending OMB's clearance.

(b) If confirmed, what actions will you take to ensure the continued success of the flight training program?

Response. The study found that 56% of the flight training recipients found employment in the field of aviation. Of this number, 60% reported that their VA flight training was instrumental in obtaining their present employment. A large number of the remainder who were employed in the field but indicated that VA flight training did not assist them in obtaining employment were still

on active duty. VBA will continue to monitor the program as closely as possible to ensure its continued success.

(c) Please provide the following information regarding the current program:

(i) the number of veterans who have participated in the program since its inception?

Response. 2,507 through December 31, 1993.

(ii) a breakdown of the various veteran populations that have participated (e.g., Vietnam-era veterans, Persian Gulf veterans)

Response. Our breakdown of training throughout the veteran populations is by education program:

Montgomery GI Bill Active Duty (chapter 30) 2,507

Montgomery GI Bill Selected Reserve (chapter 106) 266

Post-Vietnam Era Veterans Education Assistance Program (chapter 32) 287

(iii) the cost of this program, including a breakdown by fiscal year

Response.

	chapter 30	chapter 106	chapter 32
FY 1991	$181,230	$27,423	$5,564
FY 1992	$2,051,039	$351,794	$287,972
FY 1993	$3,898,089	$606,460	$538,023
1st Qtr 94	$1,945,509	$294,525	$141,158
Total	$8,075,867	$1,280,202	$972,717

(iv) a detailed explanation of any difficulties that the VA has encountered in administering the program

Response. Since the payment system is not completely automated, there have been some processing delays. We are making every effort to improve timeliness. Ultimately, however, the problem will be solved by modernization should the flight training program be extended.

In the area of program administration, we have taken action to improve the program. For example, in recent years simulator training has become the method of choice for jet aircraft ratings; however, such training was generally not included under Part 141 of the Federal Aviation Regulations. Accordingly, it could not be approved for veterans' training. In consultation with the FAA, we took corrective action on September 22, 1993, by issuing an expedited regulatory amendment. We have identified other areas to improve and streamline the program. Processing modifications and regulatory proposals to implement these are underway. If we find the law must be amended, we will submit the appropriate legislative proposals.

(v) any steps which the VA will take, or could take, to improve the delivery of this benefit to all eligible veterans

Response. See above.

WRITTEN QUESTION FROM SENATOR JEFFORDS TO MR. VOGEL AND THE RESPONSE

Question 1. With your plans to reengineer VBA's business processes, how much flexibility will be given to Regional Offices to establish their own reengineering plans and work processes? Have some offices already made substantial progress in reengineering? What changes have already been made in these offices?

Response. Business systems and practices should be designed to provide for consistent, statutorily-based decisions that are achieved through structures that recognize and take into account the many variables associated with the delivery of entitlement benefits. VBA cannot have 58 independently functioning offices. We need a system designed to provide flexibility within limits while affording consistent, high quality service delivery.

VBA will address this issue by testing and analyzing a variety of models and, when their effectiveness had been determined, making them available for implementation in Regional Offices. Regional Offices which adopt these models will then be able to tailor them to meet their needs and the needs of the customers they serve.

A number of reengineering models are currently being tested in the field. Pilot projects include the combining of the Veterans Benefits Counselor and Veterans Claims Examiner positions, the development of self-directed work teams, and the establishment of a Rating Board technician. These projects represent efforts to reevaluate and change the rating and adjudication process. For example, the establishment of the Rating Board technician increases the number of decision makers in the process and provides direct support to the Board. While varying levels of progress have been achieved, most reporting positive outcomes, a comprehensive analysis of impact and effectiveness has not yet been completed.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO MR. VOGEL AND THE RESPONSES

Question 1. Your prepared statement indicates that VBA must focus on three general areas in order to "move [VA] closer to [its] customer": Modernization; Training; and Reengineering. With respect to resolving the "adjudication backlog" specifically, please explain what these three terms refer to, and please cite examples of steps taken by VBA to date to modernize, to train and to reengineer in the context of the adjudication process.

Response. The three focus areas, Reengineering, Training and Modernization are interrelated. They revolve around the needs and expectations of our customers while directly supporting the goals established by Secretary Brown.

One goal of the Secretary is to streamline structure, procedures, and regulations and take advantage of information management and other technologies to improve internal management and delivery of services to customers. Reengineering work processes supports this goal. An example of this is the effort underway to reengineer the rating process. We are redescribing duties and redesigning procedures by the creation and introduction of a "technician" into the rating process. This "rating technician" gives management

a greater degree of flexibility and latitude in managing workload. It is anticipated that workflow will be streamlined and backlogs reduced.

Our education and training programs look to develop a workforce capable of providing timely and quality service throughout the benefits claims process. Centrally developed curriculums provide consistent instruction in the various disciplines. It is significant to note that all new veterans claims examiners taking courses at the Veterans Benefits Academy receive similar instruction. This approach to education and training contributes to the equitable application of laws and regulations throughout the claims adjudication process and leads to increased quality and improved productivity.

Modernizing our ADP environment provides opportunities for faster access to information necessary to process claims timely and in a quality manner. A concrete example of this is the introduction of a "gateway" which allows adjudicators to rapidly move back and forth between the benefits delivery network and the word processing packages. This time saving device results in expedited claims processing.

The examples given here are but a few of the ways in which Reengineering, Training, and Modernization are being used to manage our workforce and workload in order to streamline the adjudication process and reduce the claims backlog.

Question 2. Please discuss how the goals of modernization, training, and reengineering relate to each other in the context of the adjudication process. How are steps to advance any one of these goals integrated to steps to advance the others? For example, must ADP Modernization necessarily predate the elimination of an RO's "typing pool"? What lessons (if any) are to be learned from the experience of the Jackson Regional Office, which adopted a program of eliminating clerical positions even before ADP modernization was undertaken?

Response. All three are highly interrelated, dynamic, and continuous efforts directed at improved customer service. Theoretically it is reengineering efforts that lead the change process, although in reality and practice, no one single effort must "predate" the other. For example, realization of benefits from reengineering depends greatly on modernization to provide support through new tools and technologies that make processes easier to understand and less paper intensive. The example of the Jackson Regional Office demonstrates our desire to continuously evaluate work processes, in an application that was not dependent on technology to improve services.

In VBA, reengineering, modernization and training are strategically focused on improving the outcomes of the adjudication process. Our reengineering effort is the process by which more effective, customer driven business processes are identified, tested and implemented. The success of implementing simplified business processes, and identifying new ones, is dependent on the continuous education and training of our staff as they assume new roles, responsibilities, and adopt a customer focus. Modernization is a plan and planning process for using technologies to upgrade our current ADP capabilities, while designing new systems to meet the needs of the redesigned business processes.

These improvement efforts are integrated, and implemented through VBA's planning and quality improvement processes, functioning at the local, Area and

national levels. The strategic framework is developed at the national level by the Management Council, whose membership is comprised of all VACO service, and staff office directors, as well as the directors of the four geographic areas. The tactical and operating process of translating VBA strategies to specific activities and tasks occurs through the Areas and Services to the regional offices. This feedback loop works from the bottom up as well. Problems and opportunities identified at the local level through the efforts of quality action teams or during the implementation of specific tasks and activities are passed up through the Areas to the Management Council via local and Area plans.

Question 3. Are VBA's reengineering pilot projects being analyzed to determine what (if any) processes ought to be exported to other Regional Offices? If so, please identify: the indicators of performance which are being measured; the measurements (and increments of positive or negative change) which will serve as indicators of "success or "failure."

Response. All of the major VBA pilots have been designed with indicators of performance as a major component. For example, in the New York RO prototype unit, five areas of measurement have (or are being) developed: accuracy, timeliness, employee measures, cost per claim, and customer satisfaction. In Portland and Oakland, the teams are monitoring the number of cases pending, including those above and below 180 days, average days processing for several end products, and accuracy measures. In these two locations the traditional measures are augmented with qualitative data from customer focus groups. Given the nature of reengineering pilot projects, it is difficult to determine precisely at which point these indicators would show "success" or "failure." As all three of these pilot projects have been fully operational for less than a year, there has been insufficient time to make a definitive judgement on the "exportability" of certain processes. In addition, measures crucial to the determination of success, such as customer satisfaction, are just now being developed at the RO level. Most likely, it will be the long-term balance and relationship among the measures which determines "success" rather than a single indicator. Nonetheless, a major long-term goal of the reengineering pilots will be to continue to share information and identify "best practices" for use nationwide.

Question 4. It is often said that the reengineering of work processes cannot be directed or willed from above. Do you agree with this statement? If so, what is the role of management (at the Region, Area and Central Office levels) in the reengineering process?

Response. While an effective reengineering effort requires commitment and support from upper management, this alone will not insure successful results. Management at all levels of the organization must be knowledgeable, informed, committed and supportive of the reengineering effort. Reengineered business processes greatly impact the way work is done in both the central and field offices. Without commitment and support throughout the organization, we cannot hope to make significant changes in work processes.

The Reengineering Work Group, which is developing the ground work for reengineering VBA's business processes, is composed of representatives from Central Office, the programs, and Area and regional office staffs. As the effort progresses, we envision convening task teams consisting of representatives from program, Area and regional offices who are intimately knowledgeable

with benefits delivery and work processes. Not only will this serve to expand the work group's knowledge base, but it will increase ownership in the effort and enlist support and commitment throughout the organization.

Question 5. You have previously identified which Regional Offices have the highest, and the lowest, percentages of claims pending for more than 180 days. Please provide the same data with respect to each VBA Regional Office.

Response. The following table provides this data as of December 31, 1993. The stations are in order of their regional office numbers.

PERCENT CLAIMS OVER SIX MONTHS OLD
(Excludes Appeal and Herbicide Cases)

Boston	301	16.6
Providence	304	12.7
New York	306	26.0
Buffalo	307	24.9
Hartford	308	15.3
Newark	309	7.8
Philadelphia	310	13.0
Pittsburgh	311	19.2
Baltimore	313	13.0
Roanoke	314	12.6
Huntington	315	7.3
Atlanta	316	26.2
St. Petersburg	317	4.5
Winston-Salem	318	23.4
Columbia	319	19.0
Nashville	320	5.3
New Orleans	321	16.4
Montgomery	322	13.8
Jackson	323	4.5
Cleveland	325	16.3
Indianapolis	326	7.5
Louisville	327	25.6
Chicago	328	9.1
Detroit	329	12.8
Milwaukee	330	6.6
St. Louis	331	4.4
Des Moines	333	2.9
Lincoln	334	10.4
St. Paul	35	13.2
Denver	39	4.6
Albuquerque	40	8.3
Salt Lake	41	5.8
San Francisco	43	7.3
Los Angeles	344	1.1
Phoenix	45	9.8
Seattle	46	4.2
Boise	47	0.0
Portland	48	7.3
Waco	49	2.2

Little Rock	50	0.4
Muskogee	51	2.5
Reno	54	5.4
San Juan	355	33.8
Manila	358	26.4
Houston	362	19.5
Washington	372	35.8
Manchester	373	8.3
San Diego	377	23.2
Togus	402	6.3
White River	405	1.9
Ft. Harrison	436	21.1
Fargo	437	8.9
Sioux Falls	438	4.5
Wichita	452	4.7
Honolulu	459	28.0
Wilmington	460	24.0
Anchorage	463	39.5

Question 6A. It is staff's understanding that, in order to reduce the backlog of pending cases at particular Regional Offices, case files and/or personnel are being (or have been or will be) transferred from one Regional Office to another. Is this understanding correct? Please identify the Regional Offices involved in such case file or personnel transfers. Please specify VBA plans to transfer files and/or personnel in the future. With respect to each past transfer, please state whether the "assisting" Regional Office(s) had been directed by Area or Central Off ice management to accept files and/or transfer personnel, or whether Regional Office Directors were free to "opt out." With respect to future transfers (if any), will Regional Office Directors be directed to accept workload and/or transfer staff? What steps (if any) have been taken or will be taken to assure that "assisting" Regional Office employees do not believe they are being "punished" for high productivity, and to assure that "assisted" Regional Office employees do not believe they are being "rewarded" for their relatively low productivity. Have "assisted" Regional Offices been directed to initiate reengineering efforts to assure that assistance will not be needed in the future? Will they be?

Response. Your questions allude to VBA's utilization of a special group or task force we generally call a "Help Team" to alleviate a high or unusual workload at a particular station. Essentially, a Help Team gathers claims examiners at various grade levels from one or several different stations to assist in adjudicating claims, generally compensation and pension, that overburden the resources of another station. By its nature, this type of effort must be limited to extraordinary situations because it temporarily moves resources from one office to another, generally for a week or two. In some situations, adjudicative personnel such as rating specialists are detailed to the station getting help; in other situations, the actual case files are transferred from one station to another to be worked on a project basis.

Last fiscal year personnel were detailed for up to two weeks to provide assistance in working rating cases to Washington, Cleveland, Los Angeles, and Seattle; this year similar help was provided to Louisville, Winston-Salem, and Atlanta. Last week, in response to the earthquake, Los Angeles began to

distribute cases to other stations throughout the country. Within a few weeks, we expect up to 5,000 cases to be redistributed in order to provide Los Angeles the assistance it needs to handle the crisis situation there.

The temporary transfer of claims folders or detailing of personnel to do work is a collaborative VBA effort that has proven its work management value over many years. Managers are requested to assist as they can, but not to the detriment of local employees or workload needs. Temporary travel is always voluntary, and the overtime that is sometimes used to work other stations' cases is also almost always voluntary. We strive to provide the veteran the best service possible, and in redistributing workload on a temporary basis to accomplish this end, we are not "punishing" or "rewarding" employees. The stations that are providing help to Los Angeles did so voluntarily to the best of their respective abilities. The recent Blue Ribbon Panel on Claims Processing thought so much of this traditional workload management tool that it recommended we target the use of Help Teams to reduce rating backlogs when and where needed. We intend to do just this.

Regional office reengineering initiatives are currently in various stages of testing. Since we do not yet have sufficient data to evaluate these initiatives, we have not provided any directives to regional offices to initiate reengineering efforts. We believe that our VETSNET initiative to reengineer VBA's total business process will ultimately assist all regional offices experiencing workload problems.

Question 6B. What specific steps have been taken by VBA since publication, of VA's Blue Ribbon Panel on Claims Processing Report to facilitate Regional Office access to Service Medical Records?

Response. On January 31, 1994, the Navy began transferring their service medical records (SMRs) to VA's St. Louis Service Medical Records Center (SMRC). The Marine Corps and Air Force shortly will begin transferring their records to the SMRC (the Army began doing so in October 1992). Once that occurs, regional office personnel will have immediate access to all the military services' SMRs for recently separated veterans.

Question 7. An analysis of VBA's "traditional" claims processing methods (commissioned by the VBA Regional Off ice in Oakland) concluded that there are (or were) at least three contributing causes for slowed claims processing at that RO:

a. Dependence on the mail to initiate and maintain claims processing;

b. Lack of uniformity in goals and objectives between the Adjudication Division, the Veterans Services Division, and VHA; and

c. The practice of processing claims on a segmented or linear basis.

Do you agree with this assessment? Are the conclusions expressed by Oakland's consultant valid with respect to other Regional Offices?

Response. We appreciate the analysis of the Oakland consultant, Dr. Cristina Banks. Her assessment of our business process and that of others, both internal and external to VA, will ultimately assist us in reengineering to provide more efficient and better service. Dr. Banks' input helped the Oakland office develop its self-managing service delivery teams which went online in July 1993, and which are being carefully monitored.

Traditionally, adjudication divisions have viewed their work from the standpoint of quality and timeliness of claims processing actions. Veterans services divisions have viewed their work in terms of the quality and timeliness of direct personal service actions. Little has been done to tie customer views, needs, and expectations to either. This is undergoing change. A key element of some of the pilots and initiatives underway in VBA, as well as a foundation to some of the reengineering concepts being tested in places such as Oakland, New York, Portland, Jackson and Muskogee, is the merger of division-level goals and objectives into a more uniform organizational objective of customer satisfaction.

The processing of compensation and pension claims has been largely dependent on mail, primarily because most of our claims and replies to development come to our 58 regional offices by mail. We are attempting, however, to modify this situation by expanding the use of personal contact, FAX and electronic mail. Where and when this is not possible—and it will be in many situations—we are striving to improve our written communications with the customer so that he/she better understands what we are saying. Simpler language in our letters and more understandable application forms are two of VBA's goals that were strongly recommended by the Blue Ribbon Panel on Claims Processing. We are aware, as the consultant noted, that there are too many steps or passoffs in our processing of claims. We are looking to reduce the number of steps so it is simpler for the claims examiner and more understandable to the claimant. The concept of case managers who "buy into" a claim until it is completed is a key element of the reengineering initiatives being tested, and we believe that this method will streamline the processing of claims.

Question 8. An often-expressed tenet of reengineering "doctrine" is "employee empowerment." What is your understanding of this term? Do you agree that "empowerment" results in higher employee productivity? Do you believe that empowerment of one employee might be perceived by another as being his or her "disempowerment"? What training efforts (if any) have been developed by VACO, Area Directors, and/or Regional Office Directors to overcome reticence by, e.g., middle managers and rating specialists to the "empowerment" of personnel who occupy, relative to them, positions having lower pay grades? Do you believe such training is necessary or advisable as VBA reengineering efforts proceed?

Response. I believe "empowerment" to be the delegation of decisionmaking authority to the lowest level possible. This philosophy embraces the concept that the front line employees are the most aware of customer service expectations and what improvements must be made to meet these needs. Business literature indicates the practice of allowing employees the greatest degree of decision making authority practical, including making changes in the processes, provides better customer service. Research shows employees who have greater control over their jobs and the quality of service they provide experience less "cognitive dissonance" over customer needs versus management requirements, have higher morale, and are more productive.

American business has only recently moved from the more traditional command and control model of leadership, and this is true for the public sector as well. All organizations which have restructured their work processes, and correspondingly, their personnel systems, have experienced growing pains. The

disenfranchisement of middle management is one of the examples documented. Our training effort is geared towards equipping employees with the tools and knowledge necessary to provide customer valued services, including understanding the change in their roles.

Question 9. A recurring theme expressed in many reengineering plans is the necessity of adopting team approaches to work processes, and the "leveling" of job descriptions to foster teamwork and employee flexibility. Are there any statutory or other similar legal impediments to the revision of position descriptions to facilitate this reengineering theme?

Response. There are several specific personnel requirements that restrict flexibility in staffing of teams, assessing the performance and skills of teams and team members and the ability of the team to change the staffing structure to meet particular needs. However, VBA has received a waiver of a portion of the VA personnel policies and regulations and waivers of specific regulatory issues from the Office of Personnel Management (OPM). These waivers currently apply to the New York Regional Office, as a National Performance Review (NPR) test lab, and have not yet been extended to other sites.

The waiver process for personnel issues is time consuming and paper intensive. Hopefully, with the implementation of recommendations from the Report of the National performance Review, restrictive personnel policy (both within VA and through OPM) can be reduced or eliminated to allow VBA to adopt the best approach to claims processing.

Question 10. It is assumed that employee-directed reengineering efforts would result in different work process redesigns from Regional Office to Regional Office. For example, the Oakland and New York "teams" have divided work on a "digit" basis while the Portland RO "teams" specialize by the type of claim to be processed. Do you agree that reengineering efforts must be employee-directed if they are to be successful? If so, what is the role of regional office Area Office, and Central Off ice management?

Response. In a sense, all reengineering efforts are "employee directed" in that all levels of the organization need to work together to ensure success. At the service delivery level, "ownership" of the claims process is essential. Continuous improvement of these processes is enhanced by the team receiving feedback and analyzing current data on customer satisfaction, their own team performance, and other measures such as accuracy and timeliness. Regional Office Directors would still be responsible for coordinating office-wide reengineering efforts, setting current and future regional office goals, and allocating resources. The Area Directors would provide such services for a wider area, particularly by providing overall direction and allocating resources to meet area goals, and allocating resources for consultants at the RO level if needed. Central Office management would provide Administration-wide goals and strategic planning efforts, and coordination of VBA efforts with other VA elements and other government entities such as OMB, Congress, etc. Some major VBA-wide reengineering improvements, such as initiating budgetary and legislative reforms, or the creation of information systems, can only be realized through top management involvement.

Question 11. Are measurement mechanisms in place to determine the relative success of one reengineering model versus another? How will you determine, if you are confirmed, if a given pilot project is successful? Do you

believe that features of a successful pilot model ought to be, and can be, "exported" to other Regional Offices? How will you identify those features of a given pilot project that should be or may be "exported" to other Regional Offices?

Response. The various pilots in progress today are not designed to determine the single "best model" for VBA. Rather, they are independent experiments, each with their own set of measures, designed to show improvement relative to their own or the regional office's past performance. Rather than focusing on exporting the models to other regional offices, efforts during the first year of the reengineering pilots have centered on expanding the number of teams using the new processes. Once developed, certain "best practices" will be made available VBA-wide, as determined by significant improvements in timeliness, accuracy, cost-effectiveness, employee development and/or customer satisfaction. However, it is unlikely that a single model would ever fit the local circumstances of each office, given differences in customer demographics, employee mix, and local economic issues. The tools developed through these pilots, e.g. survey instruments and definition of measures, could prove to be valuable in a variety of circumstances.

Question 12. A common "reform" which appears to have emerged from a number of VBA reengineering pilots is the partial or complete integration of the Office's Adjudication and Veterans Services Divisions. Do you conclude that the efficacy of that restructuring feature has now been established? If so, please state your plans to "export" that "reform" to other ROs. If not, please indicate what data will be collected to determine whether that restructuring feature should be "exported?"

Response. For the most part, these pilots are in the early stages of development. In evaluating these pilots we are keeping two goals in mind: increased efficiency and effectiveness in claims processing, and enhanced service to our customers—service members, veterans and their families. Some of the factors being evaluated are: amount of workload, kinds and types of claims, proximity to VAMC, local economy and local demographics, and impact on other regional office divisions. Once these pilots mature and comprehensive analysis occurs, the best practices of these pilots will be made available for "export" and implementation by other regional offices.

Question 13. Various proposals for legislative change(s) have been informally forwarded to the Committee staff from various quarters. Among such proposals are:

a. The elimination of the requirement that claimants file certified copies of legal records;

b. The allowance of "single signature" authority for claims authorizations;

c. The elimination of income verification requirements;

d. The establishment of a presumption of disability, for purposes of pension at specified ages;

e. Establishment of a "threshold" for VA medical care entitlement at, e.g., a 20% disability rating level;

f. The imposition of more stringent standards of finality to preclude the reopening of claims after specified periods of time;

g. Limitations on the illnesses or disabilities which can be the basis for compensation claims; and

h. The imposition of "means testing" for purposes of compensation.

Please comment on the "pros" and "cons" of each proposal, and specify whether you would favor or oppose it.

Responses.

a. We support enactment of this measure but must assure that program integrity is maintained. We feel that any changes can be made through the rulemaking process and we are considering a regulatory change to delete the requirement for marriage and birth certificates.

b. At present, three signatures are required on all rating decisions, two lay members and one medical member. A change to single signature rating decisions would recognize the expertise of our decision makers by allowing them the authority to make decisions. It would have an immediate impact on rating backlogs as the specialists would be able to concentrate their efforts on completing rating decisions. Our overall goal is to maintain the integrity of our benefit programs while seeking methods to eliminate unnecessary case handling.

Two regional offices are currently participating in a test of single-signature ratings which will run for a one-year period from May 1, 1993 through April 30, 1994. The results of this test will help us determine the appropriate course of action to take on this issue.

c. I support giving the Secretary discretionary authority to require or waive annual income verification. However, that authority should cover parents' dependency and indemnity compensation recipients as well as pension beneficiaries.

d. Disability, not age, should serve as the primary indicator of permanent and total disability. We believe that our regulations provide pension entitlement to all veterans who truly are permanently and totally disabled. Those whose disabilities do not meet the required percentage may nonetheless receive special consideration and qualify on an "extra-schedular" basis.

e. We do not support this proposal since it would deny medical care for some service-connected disabilities. This runs counter to one of VA's primary missions and to President Clinton's health care proposal.

f. We do not believe in the imposition of more stringent standards of finality to preclude the reopening of claims after specified periods of time since a claimant is already required to meet the burden of providing new and material evidence to reopen a claim. A vital piece of evidence—one which would change the outcome of an otherwise final determination—may not become available to a claimant until after a claim has become final. In the interest of fairness, a claimant should not be precluded from reopening a claim merely because a particular period of time has passed if the claimant has otherwise met the burden of providing new and material evidence. It is VA's business to provide eligible claimants with any benefits to which they may be entitled and we do not wish to impose any deadlines which would preclude an otherwise eligible claimant from receiving benefits.

g. We do not support this provision because we do not believe that equitable limitations could be imposed. The current system, whatever its perceived faults, is fair and easy to administer.

h. We do not support this proposal. We do not favor penalizing veterans who overcome the limitations of their disabilities.

Question 14. Please describe the scope of VA activities to enhance the electronic communication (including the electronic exchange of patient medical data) among VBA facilities and between VBA and VHA facilities. Please discuss the impediments (technical, legal and fiscal) to an environment of "total connectivity."

Response. VA activities to improve electronic communication between VBA regional offices (ROs) and VHA medical centers (MCs) are proceeding along three parallel paths:

Automated Medical Information Exchange (AMIE)-provides ROs electronic access to the MCs information system, Decentralized Hospital Computer Program (DHCP). As a result of the installation of Stage I modernization equipment in ROs, VBA has been able to improve AMIE operations. Previously, AMIE was tedious and labor intensive because the only means to access DHCP was through the Wang office automation system and terminals. With Stage I, which replaces Wang and Telray terminals with personal computer workstations, it is possible for each adjudicator to have his or her own workstation. The Stage I technology can link that workstation directly to DHCP, without going through the Wang processor. The connection is much more responsive (processing times have been reduced as much as 4 to 6 times); adjudicators no longer have to leave their desks to reach an AMIE terminal; and some AMIE functions can be performed as background operations, leaving adjudicators and clerks free to conduct other work while AMIE processing is taking place. These dramatic improvements in processing efficiency now make it feasible to enhance AMIE functional capabilities. A joint user group of RO and MC representatives is responsible for determining needed enhancements and their priority.

Master Veteran Record Project (MVR) is a comprehensive project to address VA-wide needs for data sharing. The first step of this effort has identified two new data fields that will be added to the existing Beneficiary Identification and Records Locator Subsystem (managed by VBA) and made available to hospitals through the hospital inquiry (HINQ) application. Plans for implementing additional data sharing capabilities will be executed incrementally over a number of years as part of the MVR initiative.

Veterans Service Network (VETSNET) is the name of the reengineered and redesigned VBA information system resulting from VBAs Modernization Program. VETSNET is veteran, rather than benefit, centered. Data and processes will be shared among users of VETSNET. VBA has included VHA representatives in the development of its corporate business model, from which VETSNET requirements and application designs will be derived. The modeling process has identified a number of opportunities, including the Compensation and Pension examination process, for integrating VBA and VHA data processing activities. As detailed requirements for VETSNET evolve, these opportunities will be explored in depth and result in definitive specifications to be implemented as part of VETSNET.

With its Modernization program VBA has moved away from proprietary architectures into "open systems." This has eliminated a serious impediment to connectivity with VHA. The legal and regulatory requirements for competition in contracting, however, present special problems which make it difficult for both VBA and VHA (and other agencies, as well) to rapidly acquire and implement technology changes nationwide. This means that technical solutions are often conceived and understood a number of years before they can be realized. The situation presents a classic case of multiple interests, each of which is good in itself, but which sometimes work at cross purposes. VBA and VHA are continuing to share plans and strategies, however, as a means of achieving optimal outcomes.

Question 15. How much has VBA spent on automation since initiation of its current modernization program? How much has the adjudication backlog increased since the initiation of that program?

Response. To date, VBA has spent a total of $54.1 million on automation in implementing the Modernization Program. Included in this amount is $7.5 million for workstations to provide critical support for Desert Storm initiatives and to provide outbased access to the current centralized benefits delivery system, known as "Target." These workstations, purchased via the Department's NOAVA contract, are compatible with, and are being incorporated into, the modernized systems environment concurrent with modernized hardware implementation.

The remaining funds ($46.6M) have been spent on the acquisition of regional office (RO) processors, local area networks, operating systems, workstations and peripherals for each VBA facility. To date, modernized hardware has been installed at 15 regional offices and the St. Louis Records Processing Center. Nine more ROs are scheduled for modernized equipment installation by the end of the second quarter of FY 1994. The remainder of the equipment is being staged at a central location and installation should be complete by October 1994.

Compensation and Pension pending workload from 1991 through 1993 is as follows:

Sep 30, 1991 391,743

Sep 30, 1992 535,135

Sep 30, 1993 528,078

Dec 30, 1993 570,702

Question 16. The Vice President's "Reinvention of Government" proposals envision significant reductions in Federal employment. Were that program to be implemented in full, how many FTEE reductions would VA sustain? How many would VBA sustain?

Response. Based on our analysis of the report and our own assumptions, VA's share of the reduction would be 13,195 FTE and VBA's share would be 977 FTE.

Question 17. At least two VBA Regional Offices have developed tools which would appear to be appropriate for "export" to other ROs. The Jackson RO has developed a "Writing for Real People" curriculum, and the New Orleans RO has developed an ADP software package to facilitate the

preparation of award letters. What steps have been taken by Central Off ice to encourage such initiatives? What steps have been taken by Central Office to facilitate the "exporting" of those work products to other Regional Offices?

Response. We continue to support the efforts of our field stations to develop tools which provide better service to our customers. This is evident by VA's support of Total Quality Management (TQM) which has encouraged many regional offices to look for better ways to help our customers as well as ways to improve the claims process.

The Jackson Regional Office's "Writing for Real People" is a program for composing correspondence in clear, simple language. The initial phase of training in this style of letter writing was conducted for Central Office personnel during January and the final phase will be conducted in February. A project to revise compensation and pension pattern letters in this style will then begin.

The Word Assisted Rating System (WARS) was developed through joint efforts of the Atlanta and New Orleans Regional Offices. It is a sophisticated word processing package designed to assist rating specialists complete rating documents. This application was designed for a stand alone personal computer and cannot be used on our current WANG or Honeywell equipment. We are testing WARS in our new computer environment. We will then develop an implementation plan to make this application available to the field as an interim system pending the completion of our Rating Board Automation (RBA) system.

Question 18. Please describe programs being undertaken by VBA's Benefits Delivery Center in Hines, Illinois to develop ADP (hardware and software) resources to facilitate claims processing. What steps are being taken by Central Office to coordinate the software development activities undertaken at the Benefits Delivery Center and elsewhere (e.g., the New Orleans Regional Office)?

Response. We have a number of programs currently being developed to facilitate claims processing.

Personal Computer Generated Letter System will simplify the selection and generation of claims decision notifications. Testing is scheduled to begin the week of February 7.

Claims processing System will use rule-based technology to support development of all issues related to original disability compensation and pension claims. The system will identify all necessary evidence when the claim is first reviewed and generate requests to the veteran or third parties. This will eliminate piecemeal development and over-development. When a veteran visits VA to apply for compensation or pension, the information he or she supplies will be entered into the system and the application will be generated for signature. A development letter which identifies the additional information needed to process the claim will be handed to the veteran at that time.

Automated Reference Material System will replace printed copies of manuals and directives and will enable claims processors to quickly identify all laws, regulations, and directives that apply to the claims being reviewed. Overnight transmission of changes resulting from Court decisions or legislation will ensure that up-to-date information is available at all times.

Rating Board Automation will automate the production of documents by rating boards using customized word processing and data base technology. This system will make ratings more consistent, improve quality and increase output speed. It will also be possible to "program in" any future changes to our regulations and procedures. Pattern language and options will be controlled and updated to incorporate the latest policy changes.

Control of Veterans Records (COVERS) provides an automated method of tracking claims folder movement in regional offices by use of a barcode system. The system was originally developed for use on the Wang computer system and proved to be functionally valuable, but performance problems prevented widespread deployment. It is being converted for use on the stage I equipment.

Question 19. A number of VBA Regional Offices would appear to have on staff full-time TQM or Quality Improvement Officers, and at least two Regional Offices have retained management consultant services as part of their efforts to reengineer work processes. Have Regional Offices been directed by Central Office or Area Directors to establish such positions and/or to retain such services? Have all VBA Regional Offices established such positions and/or retained such services? Do you think they should?

Response. Regional Offices are encouraged and supported from both Area and Central Offices to utilize the principles of Total Quality Management in an effort to increase the quality and timeliness of work processes, provide better service to veterans and their families and improve the overall work environment. The approaches taken to integrate Total Quality Management and rates of development vary among Regional Offices.

Regional Offices which enlisted the assistance of management consultants tend to have more mature, highly developed quality programs. Consultants are utilized in the development and implementation of complex, progressive quality improvement projects that require broader management skills and experience. As has been the case with initial Total Quality Management efforts, VBA employees have been educated through the management consultants and share their knowledge throughout the organization as internal "experts", thereby reducing dependence on outside consultants. However, where necessary, offices are encouraged to take advantage of outside expertise which offers the opportunity to improve timeliness and the quality of service.

Question 20. Please identify the extent to which VBA's reengineering pilot projects have drawn on the resources of other agencies to facilitate the transition to reengineered work processes. Do you think that the resources and expertise of other Federal agencies can be, and should be, tapped to facilitate VBA's reengineering efforts? If so, please describe where such activities have occurred and identify the agency or department which provided such expertise or resources.

Response. VBA is working with the Department of Defense (DoD) and the military services on demonstration projects to improve the delivery of benefits and services to service members, veterans and their dependents. The initial demonstration project between DoD and VA is the transfer of service medical records (SMRs) from the military services to VA. It is extremely successful. The time it took to transfer SMRs from the Army to VA is reduced from 6 months to 7 days, resulting in expedited service to our customers and a

reengineered work process for original compensation claims. We continue to work with DoD and the military services to explore areas of mutual interest.

WRITTEN QUESTIONS FROM SENATOR THURMOND TO MR. VOGEL AND THE RESPONSES

Question 1. In your prepared statement, you listed numerous issues to be addressed by the VBA. What do you consider to be the chief challenge(s) facing VBA? What steps do you intend to take, if confirmed, to meet this challenge?

Response. The biggest problem, of course, is the adjudication backlog. The problem is complicated by increasing workload, and increasing complexity in that workload, at a time of decreasing resources. We are addressing this problem from two directions. First, we are rethinking the approach to structuring and managing adjudication. We are emphasizing an approach which reduces fragmentation and increases the number of staff concerned with the end result rather than a single step. We also are continuing with a heavy emphasis on quality and doing things right the first time. Second, we are now in a position to modernize ADP support to the adjudication process. This makes it possible for us to shift routine, tedious work from people to computers, giving our staff more time to focus on customer service and decision making. It also helps us to improve quality by using computers to assist in properly dealing with complex rules and rapidly changing regulations—our expert systems and automated access to reference materials are examples of this kind of support. The combination of these two approaches makes it possible for us to do more and better with fewer resources.

Question 2. While health care reform promises to take much of the spotlight this year, I am sure that you agree that many other important challenges face the VA in 1994. Are you confident that issues under your charge, for example, compensation, education, vocational rehabilitation, and programs for homeless veterans will receive appropriate attention within the VA this year? What is the basis for your assessment?

Response. We are certain there will be an impact on VBA in general and on claims processing in particular. However, the actual impact in terms of costs, resources, workload, veterans and dependents served, and service delivery methodologies cannot be determined at this time. The Department is developing an implementation plan for health care reform and VBA is actively participating in its formulation. We will make every effort to mitigate the impact on our customers and will continue the pursuit of quality and timely service within VBA.

Question 3. In your responses to the Chairman's prehearing questions, you state you are giving no consideration to making proposals for statutory revisions to VA benefits programs. Please elaborate on whether you considered any potential revisions before coming to this conclusion, and if so, what those revisions were.

Response. We have considered no potential statutory revisions.

QUESTIONNAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1 Name: VOGEL (LAST) Raymond (FIRST) John (OTHER)

2 Present address: 6220 Fairway Bay Gulfport (CITY) FL (STATE) 33707 (ZIP CODE)

3. Position to which nominated: Under Secretary for Benefits

4 Date of nomination:

5. Date of birth: 09 (DAY) 08 (MONTH) 40 (YEAR)

6. Place of birth: Wheeling, West Virginia

7. Marital status: married

8. Full name of spouse: Georgia Ann Faris Vogel

9. Names and ages of children:
Raymond John, Jr. 27
Matthew Edward 26
Anne Marie 25

10. Education:

Institution (including city and State)	Dates attended	Degrees received	Dates of degrees
Wheeling College Wheeling, WV	9/58 - 6/62	BA	1962
West Virginia Univ. College of Law Morgantown, WV	9/62 - 2/63	none	
Judge Advocate General School Univ. of VA, Charlottesville, VA	6/64 - 6/65	none	
George Washington University Washington, DC	2/70 - 1/75	none	

11 Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement

Secretary of Veterans Affairs distinguished Service Award, 1990

Secretary of the Treasury's Cash Management Award, 1987, 1989

Outstanding performance awards throughout career including executive bonuses from 1979 to the present

12. Memberships — List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and any other prior memberships or offices you consider relevant.

Organization	Office held (if any)	Dates
Tampa Bay Federal Executive Association	President	1991-1993
Federal Quality Institute	Charter Member Board of Directors	1988-1990
Combined Federal Campaign Pinellas Co., FL	Chairman	1991-1992
American College of Health Care Executives	None	1991-present
Tampa Bay Hospital Council	None	1990-present
United Way of St. Petersburg, FL	Board of Directors	1992-1993
Senior Executive Association	None	1985-present

* See attached sheet

13 Employment record: List below all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment.

Deputy Under Secretary for Benefits (Detailed)	Dept. of Vet. Affairs Washington, DC	02/93-present
Medical Center Director	VAMC Bay Pines, FL	06/90-02/93
Special Field Operations Rep	VAMC Baltimore, MD	01/90-06/90
Chief Benefits Director	VACO Washington, DC	06/85-01/90
Regional Office Director	VARO Philadelphia, PA	11/83-06/85
Regional Office Director	VARO Portland, Or	05/79-11/83
Adjudication Officer	VARO Washington, DC	06/77-05/79
Adjudication Officer	VARO Portland, OR	02/75-06/77

* See attached sheet

14. Military service: List below all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge.

U.S. Army active duty from November 7, 1963 to November 5, 1965

SP4, E-4; 2nd BN, 42nd Artillery, Ft. Benning, GA, 03/64-11/65

Field Artillery training, Ft. Sill, OK, 01/64-3/64

Basic Training, Ft. Gordon, GA, 11/63-01/64

* See attached sheet

15. Government experience: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than those listed above.

None

16. Published writings: List the titles, publishers, and dates of books, articles, reports, or other published materials you have written.

None

17. Political affiliations and activities: (a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years.

I am a registered Democrat. I have never been active in partisan I have been a career Federal employee since 1968 and the Hatch Act prohibits such activity. Since attaining voting age, I have been registered in both major parties, depending on the area in which I resided.

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved.

None

18 Future employment relationships:

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate

Since I am currently employed by the Federal government, it will not be necessary.

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization.

I plan to remain a government employee.

(c) What commitments, if any, have been made to you for employment after you leave Federal service?

None

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed?

Yes

(e) (If appointed for an indefinite period) Do you intend to serve until the next Presidential election?

Yes

19. Potential conflicts of interest:

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated

None

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated

None

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy

None

(e) Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

Not applicable

20. Testifying before the Congress:

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee?

Yes

(b) Do you agree to provide such information as is requested by such a committee?

Yes

88-271 O - 95 - 5

ATTACHMENT

12. Memberships

American Legion	none	
Disabled American Veterans	none	1970-present
Non-Commissioned Officers Assoc.	none	1986-present
American Veterans of WWII, Korea, and Vietnam	none	1978-1988
Knights of Columbus	none	1973-present
Pasadena Yacht & Country Club	none	1990-present
Montgomery Country Club	none	1986-1990

13. Employment Record

Education Specialist	VACO Washington, DC	11/74-02/75
Legal Consultant	VACO Washington, DC	05/73-11/74
Veterans Claims Examiner	VACO Washington, DC	09/68-05/73
Career Insurance Agent	Connecticut General Life Insurance Co. Pittsburgh, Pa	06/67-09/68
Mgmt.Intern/Sales Order Center	U.S. Steel Corp.	11/65-06/67

14. Military Service

I was a battery clerk and an artilleryman after completing military training. I received an honorable discharge.

APPENDIX 2.—NOMINATION OF KENNETH W. KIZER

PREPARED STATEMENT OF CHAIRMAN JOHN D. ROCKEFELLER IV

Today's confirmation hearing for Dr. Kenneth Kizer marks a turning point for the VA and for veterans across the country. For more than a year and a half, the VA has lacked any real leadership for its medical programs. We hope that we can finally rectify that situation.

The VA medical system is the largest health care system in this country, and one of the largest in the world. It is a program with many strengths, especially for veterans who are blind or have spinal cord injuries, amputations, or Post-Traumatic Stress Disorder. It is also a program with many weaknesses. One major weakness is that it lacks the resources that it needs to provide medical care for all our Nation's veterans who would like to obtain care there. However, there are also weaknesses that are created by a bureaucracy that has failed to treat veterans with the respect and fairness they deserve.

The VA Under Secretary for Health is one of the most important public servants I can think of. The next Under Secretary will guide the VA medical system at a time when it desperately needs a leader with the vision to guide the VA into the next century.

It is outrageous that this position has been essentially unfilled since February 1993, and as a result, the pressures and expectations on the new Under Secretary will be enormous. Dr. Kizer, if he is confirmed, will be the first person in that position to come from outside the VA system. While most of us believe that this will bring a much-needed fresh perspective, it also means that it could be that much harder for him to get the VA moving in new directions as soon as possible. In addition, he would inherit a system that has been controlled by others in the absence of an Under Secretary, and one that has been much too reluctant to delegate authority to the directors of the 171 VA medical centers across the country.

For the past year, the VA and this Committee have been concentrating much of our efforts on health care reform. Our goal has been to keep the VA an independent entity, while strengthening it and reforming it in the context of national health care reform. The ultimate success or failure of those efforts are now unknown, because they depend so entirely on our ongoing struggle to pass a meaningful health care reform bill.

Regardless of the outcome of that struggle—and I remain optimistic that common sense and our will to fix an unfair health care system will still prevail—the VA medical system needs strong leadership. VA also needs a leader who is strong enough to delegate authority to others. Unfortunately, it has lacked that leadership for many years. The purpose of this confirmation hearing is to convey our concerns about the need for dramatic changes in the VA medical system, and give to Dr. Kizer the opportunity to let us know how he plans to meet those challenges.

PREPARED STATEMENT OF SENATOR STROM THURMOND

It is a pleasure to be here today to consider the nomination of Doctor Kenneth Kizer to be Under Secretary for Health at the Department of Veterans Affairs. I join you and the other members of the Committee in extending a warm welcome to the nominee, as well as to his family, friends, and guests who may be accompanying him. I am pleased that the President has nominated a person of experience and ability for this critical position.

Mr. Chairman, this nominee appears well qualified for the position to which he has been nominated. Dr. Kizer is a Veteran of the United States Navy, having served as a Medical Officer. He has extensive experience in all aspects of health administration. He has served as a practicing physician, a professor of medicine, and President or Director of numerous medical programs. A partial list of programs in which he has demonstrated his knowledge and experience includes emergency medical services, environmental health, internal medicine, preventive health services, and public health. As Director of the California Department of Health Services, he served as the chief health official for the State of California, the largest state medical organization in the nation.

Mr. Chairman, as you are aware, the Veterans Health Administration (VHA) is faced with a number of important issues related to medical care, medical and prosthetic research, medical research, and administration of the largest medical system in the nation. In addition to protecting the role of the Veterans Health Administration in national health care reform, the nominee will have many challenging opportunities as he takes on the issues facing the VHA. A short list would include the provision of quality medical care, including the treatment of Persian Gulf War Veterans and veterans exposed to chemicals and radiation, women veterans health care, and preventive health care services; developing and implementing quality measures; and strengthening the VHA education programs and affiliations with educational institutions.

Mr. Chairman, I congratulate the nominee on his willingness to serve his Nation in the position to which he has been nominated. He has the ability and desire to serve. His education, training, and experience has prepared him for success in this position. This hearing will emphasize the important work he will be doing. I am confident that he will fully use his talent and ability to be a diligent steward over the health care, research and education programs of the VHA. I would underscore that the ultimate objective is to provide our Nation's Veterans with the quality medical care they deserve.

Thank you, Mr. Chairman. I look forward to reviewing the testimony of the nominee.

PREPARED STATEMENT OF SENATOR JAMES M. JEFFORDS

I would like to welcome Dr. Kenneth Kizer here today. I am pleased, as I am sure this whole committee is, to finally be able to consider filling the important position of the Under Secretary of Health at the Department of Veterans Affairs.

I am further pleased that after waiting so long for a nominee to be named that this committee has been presented with such a fine candidate to fill this important position.

I believe, more than ever, that the VA needs a strong visionary leader in VA health care reform. As we all know, there are not the votes in the Senate and probably not in the House, to pass the Clinton, Mitchell or Gephardt health care reform bills. Several of my colleagues from both sides or the aisle and I have tried to design a reasonable middle ground that will still bring significant reform to the health care system. Whatever is passed in Congress it is important that the VA be a participant. More importantly, the VA must move forward with it's own health care and eligibility reform efforts, no matter what the outcome on a national level. This committee has spent many hearings reviewing what our veterans health needs are and what direction veterans health care must move. The veterans who have advocated health care reform and the VSO's who have united in one effort to advocate health care reform will be counting on you to keep the momentum of reform alive in the VA.

As you know this is an extremely important position which you have been nominated for. I believe that you will have a large, but very rewarding challenge ahead of you in this position. I understand that issues such as the need for outpatient care and integration utilization of federal and community health providers are important to you. I believe these are important issues for the future of VA health care.

As a member of this Committee I have made a commitment to our nation's veterans and their health care needs. I look forward to working with the VA Under Secretary for Health's office in these challenging times ahead.

STATEMENT OF SENATOR DIANNE FEINSTEIN

Mr. Chairman and members of the Committee, I am very pleased to appear before you today to introduce Dr Kenneth W. Kizer, President Clinton's nominee to the Department of Veterans Affairs as Under Secretary of Health.

Dr. Kizer is Professor and Chairman of the Department of Community and International Health at the University of California, Davis, School of Medicine. He is also a Professor of Emergency Medicine and Clinical Toxicology in the School's Department of Medicine. Prior to joining the full time faculty at UC Davis in July of 1991, Dr. Kizer served for six years as Director of the California Department of Health Services. Appointed in 1985 as the youngest person and one of the few physicians ever to hold the position, Dr. Kizer worked as the chief health official for the state of California, managing a budget of $12 billion and a staff of about 7,000, while overseeing approximately 150 health care services, and public health and environmental protection programs.

88-271 O - 95 - 6

Kenneth Kizer is also a member of numerous professional societies and a fellow of several organizations, including the American College of Emergency Physicians, the American Academy of Clinical Toxicology, and the American College of Preventive Medicine. He has also been actively involved as a consultant to various corporations, law firms and other entities. As an experienced and accomplished administrator and a frequently sought after speaker on current health issues at medical and health care forums, Dr. Kizer has exhibited a keen and well developed understanding of medical and health related matters. His experience should be an asset to the Veterans Health Administration (VHA).

As you know, the VHA provides high quality medical care and rehabilitation services to about 4 million veterans. It is important that the quality of veterans health care is maintained in order to ensure that America's veterans and their families receive the treatment, support and recognition they have earned in service to the United States. I am confident that Dr. Kizer will work to promote efficiency in the delivery of veterans' health care services, and that he will be an exceptional Under Secretary of Health at the Department of Veterans Affairs. This being the case, I support Dr. Kizer's nomination and look forward to his confirmation.

PREPARED STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., NOMINEE TO BE UNDER SECRETARY FOR HEALTH FOR THE DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, I am pleased to be here today as President Clinton's nominee to be Under Secretary for Health in the Department of Veterans Affairs. I am honored to be considered by you for this position.

Mr. Chairman, while I have significant experience with the VA, my professional life has been spent outside of the Veterans Health Administration, and I believe that my presence before you today is an affirmation of President Clinton's and Secretary Brown's interest in seeing new ideas and new perspectives brought into the system. Having said this, though, I would also note that much of my professional life has been in government service. This includes several years as a Naval medical officer and, more recently, nearly eight years leading health agencies for the State of California.

Mr. Chairman, if I am confirmed as Under Secretary, I believe that I would bring to the position a mix of relevant private sector and public sector management experience. In particular, I might note that during the more than six years that I served as California's top health official, and more recently in my positions at the University of California and with the California Wellness Foundation, I have been very much involved in health care reform. Indeed, some of the health care reform activities that I was involved with in California have been held out as models for consideration in the national health care reform debate.

I believe that my experience in this regard would be very useful to the Veterans Health Administration as it adapts to a very rapidly changing health care environment and as new paradigms of treatment and health service delivery become the norm.

If the VHA is to provide superior quality health care at an affordable cost in the 21st Century, then it must reorient itself so that its normal modus operandi is one of local and regional integrated networks of service delivery having strong ambulatory and long term care components and one that takes advantage of advances in medical informatics and electronic information processing. It needs to be a system that focuses on the entire person and which integrates medical care with other services provided by the VA and in which male and female veterans are accorded the same priority and sensitivity.

Mr. Chairman, I have kept these remarks brief so as to maximize the opportunity for dialogue with the Committee. Let me conclude by saying that if I am confirmed, I look forward to an open and productive relationship with you and this Committee, as well as the other members of Congress who are not here today.

WRITTEN PREHEARING QUESTIONS FROM CHAIRMAN ROCKEFELLER TO DR. KIZER AND THE RESPONSES

Question 1. What is your concept of the nature and extent of the Federal Government's obligations to the Nation's veterans, especially in the area of health care?

Response. I believe the federal government has a special obligation to the men and women who have served this nation in its uniformed services, and especially for those who served in times of armed conflict. Congress has enacted many laws codifying the government's obligations in this regard. The services provided for veterans at VA medical facilities should be easily accessible, compassionate, and of superior quality. The system that oversees these facilities should be flexible enough to accommodate the varied circumstances and needs of veterans in the far reaches of this large and diverse country. Likewise, the system should be visibly efficient and cost beneficial so that the taxpayers can see that their tax dollars are being used wisely and productively.

Question 2. Section 305 of Title 38, United States Code, requires that the Under Secretary for Health be appointed "solely on the basis of demonstrated ability in the medical profession, in health care administration and policy formulation, and in health care fiscal management, and on the basis of substantial experience in connection with the programs of Veterans Health Administration or programs of similar content and scope. Please describe the specific experiences which you have had that satisfy the requirements of "demonstrated ability in . . . health care administration and policy formulation, and in health care fiscal management."

Response. I would bring to this position a variety of management experiences in both the public and private sectors, as well as in academia. Probably the most relevant experience that I would bring to the position is the over six years that I served as the Director of the Department of Health Services for the State of California. In this capacity, I served as California's top health official, managing a budget of $13 billion and about 150 health care financing, health protection, public health and environmental protection programs. Among the specific programs that I had responsibility for were the nation's largest Medicaid program (Medi-Cal), which funds health care for more than 5 million beneficiaries annually; the licensure and certification for

Medicare and Medicaid participation of more than 5,300 health care facilities (This included 525 general acute care hospitals, 1,300 nursing homes and nearly 3,500 other facilities in 16 additional licensure categories.); a panoply of public health programs, including the most comprehensive state AIDS program in the nation; and the state's hazardous waste and toxic site remediation programs. (At this time, much of California's EPA function was carried out by the Department of Health Services; this is now handled by the California Environmental Protection Agency, which I helped design.) More new programs were conceived, developed and implemented, and more established programs were revamped, during my tenure than at any other comparable time in the Department's history— and this was during a time of substantial fiscal restraint. Many of the programs developed and implemented during my tenure have received national or international acclaim. Likewise, I was directly involved in the inception of various health care reform measures, some of which have been cited as models for national reform (e.g., the statewide Health Insurance Purchasing Cooperative). Prior to assuming the directorship of the California Department of Health Services, I served as Chief Deputy Director for Preventive Health Services and Chief of Public Health Programs for the Department, having primary responsibility for managing a budget of about $1.5 billion and an array of public health programs that included an indigent health care services program, food and drug safety (the state's FDA function), radiological health, drinking water safety, environmental hazards assessments, maternal and child health, the Women Infants and Children supplemental food program and many others. Before joining the California Department of Health Services, I was the Director of California's Emergency Medical Services Authority, a small department charged with developing and overseeing the state's emergency medical services program, as well as being the lead agency for disaster medical planning. Since leaving state government in 1991, I have served on the Board of Directors of a number of nonprofit organizations. These include the Robert J. Mathews Foundation for Prostate Cancer Research; the Center for AIDS Education, Research and Services; Eagle Lakes Children' Charities and Camp Ronald McDonald at Eagle Lake; and the California Wellness Foundation. All of these Board positions have involved financial management experience. I might particularly note that during my tenure on the Board of the California Wellness Foundation (CWF), we have increased the assets of the Foundation from $300 million at its creation in 1992 to approximately $1 billion in 1994. (This rapid increase in assets was due primarily to the fact that the CWF was the principle shareholder of Health Net, a large HMO, which merged with QualMed, a Colorado-based HMO, in late 1993, giving rise to Health Systems International, Inc. (HSI), one of the nations' larger HMOs. The California Wellness Foundation is the majority shareholder of HSI. Recently, I was elected to the Board of Directors of HSI, as well). I might also note that in the last three years that I have served as Chairman of the Department of Community and International Health at the University of California, Davis, I have overseen an increase in the Department's extramural funding from about $1.5 million to nearly $9 million. While we are the smallest, in terms of faculty, of the 23 departments in the UCD School of Medicine, we now have more extramural funding than all but one department. Overall, I believe I bring to the position of Under Secretary for Health a diverse and broad managerial background, as well as established technical competence in various medical specialties.

Question 3. As Under Secretary for Health, you would be responsible for managing a program of over 200,000 employees. Please comment on those aspects of your experience which involve the management of such a large, widely dispersed, and varied workforce.

Response. As Director of Health for California, I was responsible for managing a staff of about 7,000 in some 160 offices located throughout California's 158,000 square miles. In California there is a well developed county/local health department infrastructure that actually carries out many of the programs funded by and/or the policies established by the state department, so, in effect, the health department "staff" is many times larger than those employed just by the state. In this regard, I also might mention that the California Department of Health Services (CDHS) was relatively unique among the nation's state health agencies, being responsible for programs typically managed by 3 to 5 agencies in other states. The major program areas overseen by the CDHS during my tenure were public health; Medicaid; licensure and certification of health care facilities; food, drug and medical device safety; and hazardous waste management and toxic site remediation, as well as other environmental protection programs. As far as personnel, we employed persons in more than 450 civil service classifications (the most of any state agency) and we worked with 16 of the 21 state recognized collective bargaining units (again, more than any other state agency). Overall, the Department of Health Services was widely regarded as the most complex and hardest to manage agency in California state government. It was also widely acknowledged to be responsible for a markedly disproportionate number of sensitive, controversial, and high profile issues. These included AIDS and other communicable diseases, indigent health care, food and water safety, nursing homes, hazardous waste, biomedical waste, environmental contamination, radiation safety, birth defects, cancer, and antismoking programs. I might further note that during my tenure in the Navy, I worked with far flung commands. For example, as the Group Medical Officer for Explosive Ordinance Disposal Group One, I was responsible for 48 units operating between the Rocky Mountains in the U.S. and the Indian Ocean. Likewise, as a Submarine Squadron Medical Officer (assigned either permanently or acting) for several submarine squadrons, I was responsible for more than 30 submarine crews operating in highly diverse locations. In sum, I believe I have an established record of managing large numbers of employees having varied functions and being geographically widely dispersed.

Question 4. If confirmed, to what extent do you believe management decisions should be decentralized? For example, in S. 1974, the Committee's VA State Reform Pilot Program bill, some decision making authority is transferred down to a more local level, so that VA facilities will be able to compete more easily with other local health care providers.

Response. Conceptually, I believe management decisions should be made at the lowest possible level, i.e., closest to where they will have to be implemented and "lived with." Likewise, in the abstract, I favor decentralized management. However, I also believe that managers should be held accountable and responsible for their decisions. This is especially so for decentralized management to be effective in a large organization. In such cases, management goals and expectations must be clearly articulated and widely understood. Having said this, I would respond to the specific question by noting that while I am generally aware that the VA has promulgated a proposal whose purpose

is to decentralize management, I would want to take some time to consider how the management precepts noted above would be best implemented in the large and far flung VA health care system, especially with regard to the plethora of laws and administrative policies that currently govern it. Likewise, I would want to review the existing, planned and alternative management structures and the general qualifications of the pool of VA managers before making a judgment about what structure would best facilitate VA health care managers being successful in today's changing health care environment and in an era of budget restraint. My goal would be to achieve a balance between local responsiveness and efficiency and the need to maintain the system's integrity and accountability.

Question 5. If confirmed, what management style do you envision using? For example, would you tend to require that issues be settled before reaching you and that you be presented with compromise or consensus recommendations, or would you prefer to hear competing views and resolve conflicts yourself?

Response. If issues were all to be settled by consensus or compromise before reaching me then my position would be redundant and should be eliminated. In general, I encourage decisions to be made at the lowest level possible, consistent with established policies. I believe in giving subordinate managers the responsibility for making decisions, as well as holding them accountable for their actions. For issues needing to be resolved at the Under Secretary level, I would expect them to be thoroughly researched and the criteria upon which the decision should be made to have been identified. I expect that my subordinate managers will disagree on issues. I would want to hear their views and their reasoning. I anticipate having to choose among the alternative views. In such cases, I would anticipate seeking advice from outside sources, when appropriate or necessary, including other federal agencies, academia, professional societies, veterans service organizations, and members of Congress, among others.

Question 6. What are your plans for reliance on career employee managers and internal advisory committees for advice, as contrasted with hiring consultants and special assistants?

Response. The VA will need an abundance of creativity if it is to prosper in the future. As Under Secretary, I would intend to seek advice from within and from outside of the organization. Clearly, I would rely on career employee managers for advice and support in managing the veterans' medical program. I would rely on them as we embark on new and innovative ways of doing things. I would also plan to seek the advice of established advisory committees and the various veterans service organizations, individual members of Congress and relevant congressional committees, academia, and other individuals and organizations interested in improving the veterans medical program.

I would anticipate using consultants to assist in specific problem resolution or in the design and development of new technologies or new service delivery models. Similarly, I may utilize outside experience in enhancing the VHA's quality improvement infrastructure based on what I find after reviewing current activities in this regard.

Question 7. Under VA's most recent proposal to reorganize administrative operations, the so-called Veterans Service Area proposal, VA's four regional offices would be abolished and 16 more local offices would be established.

What is your view of this proposal, and in answering indicate if your view differs depending on whether health care reform is enacted.

Response. I would refer you to my response to question 4 and again note that I will need to study the reorganization proposal before making a recommendation to the Secretary. Should a comprehensive health care reform proposal be enacted this year, I would factor that into my consideration.

Question 8. What is the philosophy you would draw upon when making decisions about a) the closures of VA hospitals and b) construction of new inpatient facilities?

Response. Any capital construction proposal for health care facilities should address the current and future needs of the population being served. In light of the changing nature and role of the general acute care hospital, one would have to carefully consider the need for additional traditional inpatient facilities. Instead of focusing on hospitals per se, the VHA should instead focus on integrated networks of services that can provide a cost-effective, seamless continuum of care.

Question 9. What is your feeling about major Central Office VHA service or program directors having their own advisory committees of field managers?

Response. In a system as large and complex as VHA, there is a need for advisory committees at all levels.

Question 10. What is your general philosophy regarding the use of decentralized pilot programs and test stations for research and development purposes?

Response. I strongly believe in the value of pilot programs to research and develop new and better ways of doing things. The VA is in a unique position to evaluate various models of providing health care services. I would hope to increase the VA's efforts to improve its delivery system through an expanded menu of pilot projects.

Question 11. Current eligibility rules are such that VA must provide inpatient care to a greater number of people than outpatient care. The more generous inpatient benefits were required by law, and more limited outpatient services were added in later legislation. What is your view about such restrictions on care?

Response. I know that eligibility rules for VA medical services are complex and that there is a need to simplify them, particularly for outpatient care. The VA must provide easily accessible care in a cost-effective and timely manner. The eligibility rules should be consistent with good medical practice, and they should be understandable to veterans and others. And insofar as medical care is increasingly being delivered in outpatient settings, VA rules must accommodate the rapidly developing outpatient medical technology and changing role of the acute care hospital. Many conditions which were treated by inpatient care only five years ago are now routinely treated on an outpatient basis in the private sector. New drug delivery systems, minimally invasive surgical technologies, improved diagnostic imaging modalities, and other medical technology that has become widely used in recent years, or that will become widespread in the next few years, will make much inpatient care obsolete. With these new technologies, though, will come the need for more home care or convalescent care. The laws and administrative policies that

govern VHA must not impose a barrier to veterans receiving state of the art medical care.

Question 12. Various health care reform proposals include provisions to modify the ratio of generalists to specialists by allocating medical school resident slots to reflect this change. What do you think the effect would be on VA, or any other provider which depends heavily on residents to reinforce physician staffing levels?

Response. I expect the VA to be a leader in developing generalist resident training programs with its academic affiliates. What effect this will have on the system's reliance upon residents is something I will need to look into.

Question 13. Please describe your philosophy regarding the overall value of academic affiliations, including the role affiliates play in staffing VA facilities.

Response. I believe that affiliations between academic medical centers and VA facilities allow the sharing of technologies, services and manpower that can be mutually beneficial. To date, both the VA and academia have generally served populations not sought after by the private sector, so there are some potential natural synergies here. I think that affiliations with academic medical centers also can work to improve the quality of care provided at VA facilities.

Question 14. Please describe what you see as the future role within VA for non-physician providers, such as physician assistants and advanced nurse practitioners.

Response. I strongly support the appropriate use of physician assistants and advanced practice nurses. As VA transitions to a primary care focus, I would anticipate increasing use of both of these types of providers.

Question 15. As the Director of the Department of Health Services for the State of California, I am sure you are familiar with California Public Employees' Retirement System (CalPERS). Please describe CalPERS' experiences as a manager of health care that you believe can be translated to VA, now, and under the President's health care reform proposal?

Response. The principal manager of the CalPERS health care program, Mr. Tom Elkin, is one of my former managers from the Medi-Cal program. I recommended him for the CalPERS job, and I am pleased to see the notoriety that he has enjoyed in this position. I would like to think that part of what he has achieved has been due to principles he learned at the Department of Health Services.

One of the basic principles that CalPERS has utilized is to get private contract providers (e.g., HMOs) to compete on the basis of price. In order to do this, CalPERS had to require that all insurance carriers offer the same benefit package in order that legitimate price comparisons could be made. If competition is to be effective then it must be on the basis of comparable products.

Another principle that CalPERS has utilized is that of leveraging its large number of beneficiaries to get better prices. Again, this is a fundamental approach that we routinely employed in Medi-Cal and which could be utilized for any group having a large number of beneficiaries.

CalPERS has also required that their contract plans be accountable for the quality of care they provide. Again, this is a familiar principle that we espoused

at the California Department of Health Services and which is certainly applicable to the VA.

Question 16. Are you giving consideration to making any revisions to VA's strategic plan for health care reform? If so, please describe the perspective and philosophy you would bring to consider any possible changes.

Response. I will need to study the VHA's plan for health care reform before I make any definitive judgments. Much will depend upon the outcome of the current national debate on health care reform. Veterans health care needs must be addressed in this debate.

Question 17. In terms of making VA facilities competitive with other health care providers, what changes do you envision for VA in the near and far term?

Response. I understand that the initial plans are for movement to a managed health care system with a primary care foundation. As I become more familiar with specific details, I expect that I will develop an appreciation of what additional changes are necessary.

In any structure that might be proposed, I will put a strong focus on delivering superior quality care that is both timely and compassionate.

Question 18. Currently VA uses an average cost to bill third party payers for nonservice-connected care provided to veterans. Anecdotal information suggests that by using an average cost rather than the actual cost of providing care, VA has difficulty in obtaining reimbursements from third parties for care that is below average cost. In your view is it necessary and equitable, now, and in a reformed health care environment, for VA to bill for the true cost of care?

Response. I believe that the VA should bill for at least the true cost of care and should be aggressive in its efforts to recoup payment. I have been advised that several key issues in this respect are being addressed that will better position VA for its transition into health care reform. I am advised that the VA currently has a large study underway examining the appropriateness of their per diem billing and what changes should be made to enhance their collection efforts. I need to review this study before making any specific recommendations.

Question 19. Would you agree that whatever funding scheme is used by the VA to allocate resources throughout the system must provide sufficient reimbursement for the clinically accepted methods of treatment for service-related disabilities, as well as encourage the rendering of care in an efficient manner?

Response. I agree. I believe that whatever funding process is used, there should be a medical informatics foundation for both the identification of resource requirements and for making informed management decisions that support efficiency and good patient care. It is essential to have a system in place that allows one to determine actual cost of care.

Question 20. What is your general philosophy regarding the use of Automated Data Processing in health care organizations, and, specifically, what is your view about the effectiveness of the Decentralized Hospital Computer Program as a means to determine the actual costs of providing care?

Response. I strongly support automated data processing (ADP). ADP is essential to the efficient operation of any health care or other service

organization. These systems must be user friendly, however, and they must be flexible enough to accommodate changing circumstances.

As regards the ability of DHCP to determine the actual cost of providing health care, I have been advised that with the system-wide implementation of a recently acquired commercial cost accounting and management support system, accurate costs of a procedure or test will be available. However, I need to study this issue further.

Question 21. What, in your view, could be done to expedite the development of a new system to improve VA billing procedures?

Response. I have been advised that there already is a major system under development that will allow for the electronic submission and collection of those billings. Before making recommendations on what further efforts might be undertaken to enhance VA billing procedures, I would want to become familiar with the efforts already underway and to study alternatives or enhancements to those efforts.

Question 22. What are your ADP goals, and what priority do you plan to give ADP in your budget submission for FY 1996 and beyond?

Response. As I have indicated before, I am a strong supporter of automated data processing. I also believe the Veterans Health Administration provides a unique opportunity to test and develop new ADP technologies. However, before indicating a specific priority that ADP would have in the FY 1996 budget submission, I would want time to assess what we are currently doing and how needs in this area compare with other priorities.

Question 23. As you know, VHA has been asked for years to do more with less and less. On the one hand, VA will have to compete with private health care providers under national health care reform. On the other hand, the federal government will have to be cut by 272,900 FTEE over the next five years, some of which will have to come from VA. Your nomination comes in the middle of negotiations between Congress and OMB to find an appropriate FTEE level for VA.

Question 23A. What is your general feeling about the staffing levels in VHA as VA enters health care reform?

Response. In general, I believe there should be enough staff to do the job that is mandated by Congress and to provide the level of service which veterans should expect from the VHA. At this point, I do not feel that I could reliably espouse any specific recommendations about staffing levels at the Veterans Health Administration.

Question 23B. OMB currently estimates that VHA would have to cut 25,000 FTE in the next five years. How do you plan to achieve these cuts while maintaining, and possibly expending, medical care for veterans?

Response. I understand that the VA has submitted certain proposals to the Office of Management and Budget in response to the National Performance Review guidelines. I have not yet had a chance to review those proposals or to study existing VHA staffing such that I could reliably recommend where FTE reductions might be most reasonable to occur.

I do believe that enhanced automated data processing and other electronic technologies can enhance the performance of staff such that in some cases FTEs may be redirected to other priority programs.

Question 23C. What are your views on the need for flexibility to hire and fire employees in VHA?

Response. If the Veterans Health Administration is to operate in a more "business-like" manner and to successfully compete in the rapidly evolving health care environment, then it must have flexibility in hiring and terminating employees. I have not yet come to a conclusion as to whether sufficient flexibility currently exists.

Question 23D. What do you think about VHA becoming a "quasi-governmental" corporation in order to create a more competitive and market-driven veterans health care system?

Response. At this time, I neither support nor oppose the notion of the Veterans Health Administration becoming a "quasi-governmental" corporation. Before coming to a conclusion on this issue, I would want to make sure that the VHA had taken all possible steps at its disposal to operate more efficiently. Based on my experience with California government, I believe that government can often operate more efficiently and be more responsive to its constituents than historically it may have done. Likewise, experience from corporate America certainly has demonstrated that private corporations are not immune to bureaucracy and stagnation. There are many examples in the steel, automotive, electronics and aerospace industries where large corporations have functioned no better than the worst of government agencies.

Question 23E. What do you believe is the proper role of VHA Central Office in a "reformed" health system, and how would you intend to implement changes in that function?

Response. The proper role of the Veterans Health Administration Central Office is to provide strategic leadership, funding, statutory and administrative authority, and management oversight for the field operations where medical care and other services are actually delivered. Central Office staff should provide the tools that allow VA medical facilities to provide timely, compassionate, and superior quality health care and other services to veterans. The Central Office also must provide the management accountability for the various components of the system.

Question 24. What do you see as VHA's responsibility with regard to providing outreach to potential or eligible users of VA medical centers, outpatient clinics, and Vet Centers, at homeless centers, military installations, State Employment offices, and prisons, to ensure that veterans are informed of their entitlements or eligibility on a resource-available basis?

Response. Clearly, it does no good to provide services if potential beneficiaries are not aware of the services. Therefore, providing outreach is a key element in the delivery of any VHA service. My experience in California's Medicaid and other health care financing programs has certainly impressed upon me importance of outreach. I would defer judgment on the adequacy of the VA's outreach efforts until such time as I have had an opportunity to become more familiar with those efforts.

Question 25. What are your views on the relative value of having doctors as hospital directors?

Response. Being a physician can be an asset to a hospital director, but I do not believe that having an M.D. degree should be a requirement for being a hospital director. The primary criteria that should be utilized in the hiring of a hospital director should be the needs of the job and the management experience and other relevant qualifications of the candidate.

Question 26. Please describe any recruitment and retention problems involving health care personnel you have seen in California's health care facilities. What effective methods have you seen used in the past to hire and retain nurses, physicians, dentists, physicians assistants and other providers?

Response. The health care staffing situation in California is similar to that found elsewhere in the country in that in some parts of the state there are few problems and in other parts of the state there are immense problems because of geography, cost of living, crime, and other factors that influence the willingness of people to live and work in a given community. Solutions to problems in this regard have to be tailored to the specific issues and concerns of the community in question.

Question 27. If confirmed, what priority would you give to increasing the pay for VA's physicians and dentists, especially since locality pay was not extended to these professionals this year?

Response. While I believe that the Veterans Health Administration must offer competitive salaries for physicians and dentists in order to attract and retain a qualified professional staff, I am not prepared, at this time, to make any specific recommendations in this regard. In considering this issue, one also must be cognizant of what is happening with physician and dentist pay in the private sector as a result of the movement towards managed care and a more competitive health care environment.

Question 28. Over the last few years, VA has had increasing difficulty recruiting and retaining an adequate number of high quality nurses. Please describe what you see as the current role of nurses in the VA health care system, and how that might change, if at all, over the next 20 years.

Response. Nurses are the backbone of any health care system, and they will continue to be in the future. I envision an expansion of the opportunities available to nurses to pursue more specialized skills. Indeed, I think the future of advanced practice nursing is a very bright one in both the VA and private health care sectors.

Question 29. If confirmed, will you retain the Assistant Chief Medical Director for Nursing Programs as a position?

Response. Historically, I have been very supportive of nursing and nursing programs, and I would expect to continue to be so in the future. At this time, I have made no decisions on whether to retain the Assistant Chief Medical Director for Nursing Programs or any of the other similar positions. Clearly, I want to gain additional experience in the management of the Veterans Health Administration before I make any decisions in this regard. However, I would envision nursing as having a prominent position in any organizational structure that might be proposed.

Question 30. What is your view of the need for health care facilities to have detailed mission statements?

Response. Health care facilities, like other entities, need to have mission statements, but by their very nature mission statements should not be too detailed. They do need to be specific enough that every employee knows the mission of the organization. I am accustomed to seeing detail specified in the management or business plan for the organization and not in the mission statement per se.

Question 31. What is your view of the need for groups of facilities, constituting a health care network, to have coordinated mission statements?

Response. If a group of facilities is to function effectively as a health care network, then it must have a coordinated mission statement.

Question 32. I feel strongly that VA research not only makes a major contribution to our national effort to combat disease, but also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention.

Question 32A. What are your views on the importance of VA research compared to funding for services?

Response. I believe that research is a central component of the Veterans Health Administration and should be maintained at some level. I also believe that the primary mission of the VHA is to provide services for veterans, and thus, I see funding for services as being our primary budgetary priority.

Question 32B. In your view, what are the goals of VA's research programs?

Response. The goals of the VA's research programs should be oriented towards and supportive of the mission of the Veterans Health Administration.

Question 32C. What are your general views regarding the role of VA in sponsoring medical and prosthetic research?

Response. The VA seems uniquely positioned to do research into prosthetics, and I am supportive of such activities.

Question 32D. How do you think VA should allocate its limited research funds among the general areas of basic, applied clinical, and health services research?

Response. While I would defer a specific answer to this question until I have had a chance to review existing VHA sponsored research programs, my inclination is to favor health services and applied clinical research. I am open to hear arguments for particular allocation schemes, but I have an intrinsic bias towards supporting research that would help improve the delivery of care within the Veterans Health Administration.

Question 32E. With medical centers located throughout the United States, VA touches patients and facilities of perhaps every type in terms of demography, income, geographic location, affiliation status and strength and size, and age. This seems to me a close-to-ideal environment in which to observe, if not more actively experiment with, variations in practice patterns, effectiveness of service organization, and other topics—along with the kinds of multisite cooperative clinical research projects with which VA is already involved. Findings from potential VA research could not only be applied to VA

programs, but also be used to inform nationwide discussions about medical care effectiveness and universal health care coverage. What are your thoughts on this?

Response. I generally agree with your observation. I believe the Veterans Health Administration is in a unique position to evaluate and pilot various models of care, and I would be supportive of expanding our activities in this regard. Frankly, this prospect is one of the things that attracts me to the position of Under Secretary for Health.

Question 33. What are your views on VA-DoD sharing arrangements?

Response. In general, I believe that sharing arrangements are good and can be mutually beneficial to both the VA and the Department of Defense.

Question 34. What are your views on VA sharing agreements with other Federal agencies, on VA sharing agreements with academic affiliates, and on sharing agreements with community-based clinics?

Response. Similar to my response to the last question, I generally believe that sharing agreements with other federal agencies and academic institutions can be mutually beneficial. I would want to ensure in any such arrangement, however, that it worked to the benefit of veterans and did not result in any decrement in services to them.

Question 35. What, if anything, will you do to promote all these types of agreements?

Response. The economics of health care will be the major impetus promoting sharing arrangements. I expect to encourage all VA facilities to undertake a careful analysis of ways that such arrangements could enhance the services provided to veterans. Whenever these arrangements are effected, I would want to take full advantage of the leverage that the VA might be able to exert due to its large client base.

Question 36. In pushing forward with total quality management, many hospital CEOs are changing their focus from preservation of the status quo to meeting the needs of the customers. This seems even more important for VA medical centers. What ideas do you have for establishing a quality management plan which aims to provide the best clinical outcomes for patients, while assuring patient satisfaction with VA facilities and personnel?

Response. The Veterans Health Administration exists to serve the needs of veterans. That should be the cornerstone upon which the VA operates and the benchmark by which it provides services.

I would defer making any specific proposal regarding quality management plans for the VA until I become more aware of what is currently being done in this regard.

In the way of background, I might note that when I was the Director of the California Department of Health Services I implemented a total quality management program for that department which was unique in state government at that time. This involved hiring an individual on my executive staff whose sole function was quality improvement. Each program area had to develop a quality improvement plan; all 800 of our supervisors and managers underwent specific quality improvement training; and we integrated total quality management principles throughout the operation of the department. We

were able to show some dramatic improvements in areas ranging from the processing of treatment authorization requests in the Medi-Cal program to the time it took to process travel claims in the Administrative Division. Overall, this effort was viewed quite positively, and it received a number of awards. Our successes in this regard prompted the Governor's Office to subsequently promulgate an Executive Order encouraging all departments to pursue quality management programs.

Question 37. If confirmed as Under Secretary for Health, would you try to redefine either the goals, activities, or organization of current QA procedures and philosophy and, if so, in what manner?

Response. As I noted in my response to the previous question, I would defer, at this time, specifying whether, and if so how, I would redefine any current quality assurance procedures being pursued by the Veterans Health Administration. I would note, however, that quality improvement will be a substantive focus of my efforts and that I would expect quality improvement efforts to be pursued at all levels of the organization.

Question 38. What are your views on the development and use of practice guidelines and parameters, especially in complex areas, such as the treatment of spinal cord injury or dysfunction?

Response. I generally support the development and use of practice guidelines. I believe that they can be particularly useful in the management of complex medical problems such as central nervous system injuries. However, I do not believe that practice guidelines should be used to supplant sound medical judgment. To be truly beneficial, practice guidelines must be able to show their cost efficacy.

Question 39. As part of this Committee's oversight role, we need to understand how to distinguish true quality problems from disgruntled patient or employee complaints. Can you offer any suggestions?

Response. It is often difficult to immediately distinguish whether a complaint stems from a true quality problem or whether it is merely an expression of dissatisfaction from a disgruntled patient or employee. Having ongoing quality assurance mechanisms in place that rely on objective parameters, as well as patient satisfaction measures, can be helpful in this regard. Clearly, any complaint should be supported by factual information, and this information should be able to be verified or refuted by the quality assurance mechanisms that are in place.

If confirmed, I would like the opportunity to assess what the Veterans Health Administration currently has in place in this regard and to base any recommendations for changes on this assessment.

Question 40. A June 1993 report by the VA Inspector General identified problems, such as access to care, lack of privacy, non positive attitudes, and lack of medical expertise, that VA had in serving the medical needs of women veterans.

Question 40A. What is your view of VA's programs for women veterans?

Response. Women veterans should expect no less quality of care nor any less sensitivity to their needs than male veterans. I am advised that the Veterans Health Administration has made significant progress in meeting the

needs of women veterans in recent years, but I also have heard that further improvement could be achieved. I will be insistent that the VA is responsive to the needs of women veterans.

Question 40B. Do you have any specific plans for actions in this area?

Response. I will defer espousing any specific plans for action in this area until I have had the opportunity to evaluate what is currently underway and where deficiencies need to be rectified. In this regard, I am certainly open to the input of advisory committees, as well as from members of Congress.

Question 41. Will you retain the Women Veterans Coordinators at each VAMC?

Response. At this time, I know of no reason why I should not retain the Women Veterans Coordinators at each VA Medical Center.

Question 42. Do you have a sense of what type of reorganization and reallocation of support staff and resources should take place so that women's health services receive more attention? If so, please describe your ideas.

Response. I have not had sufficient time to formulate any specific plans regarding any potential reorganization or reallocation of resources for women health services or, for that matter, any other VA program.

As an aside, I might mention that in my recent capacity at the University of California, Davis, I have been very supportive of efforts to investigate women's health issues. Indeed, UC Davis is one of the two vanguard centers in California that are being funded as part of the NIH sponsored national Women's Health Initiative. One of my faculty members is a principal investigator in that effort.

Question 43. Please describe those aspects of your background and work experience that indicate your commitment to mental illness research and mental health care for veterans.

Response. In California government, there is a separate Department of Mental Health, and thus, as Director of the Department of Health Services I did not have direct responsibility for management of mental health facilities or research into mental health care issues. However, as the licensor for the state mental hospitals I took a number of enforcement actions against these facilities in the interest of improving care for the mentally ill. These actions sometimes put me at odds with the director of the Department of Mental Health; however, I have always taken the position that patients in mental health facilities deserve the same standard of care that is provided in other health care facilities.

I have had some exposure to VA psychiatric care insofar as I spent the last six months of my senior year in medical school working at the Veterans Administration Medical Center at West Los Angeles (Brentwood Division) providing physical examinations and other medical support for veteran patients with psychiatric disorders at that facility. Likewise, I have a longstanding interest in neuroscience issues, and my undergraduate honors program at Stanford University focused on the mechanisms of learning behavior. This research was performed at the psychiatric facility on the grounds of the VA Medical Center in Palo Alto.

Question 44. The General Accounting Office, in a 1992 report entitled "The Quality of Care Provided by Some VA Psychiatric Hospitals is Inadequate,"

noted serious deficiencies in the identification and resolution of quality-of-care problems at VA psychiatric facilities. Please describe your views on the state of VA's neuropsychiatric facilities, in which areas you see needs for improvement, and how you would ensure that the quality of care provided at these is ensured.

Response. I have been apprised by VHA staff that virtually all of the items noted in the 1992 GAO report have either been fully resolved or are being addressed. Likewise, I have been advised that according to the Joint Commission on Accreditation of Healthcare Organizations that the quality of care in most VA Neuropsychiatric hospitals is high. I would, however, like the opportunity to come to my own judgment in this regard, and this will require some period of time working with these institutions. After coming to my own conclusion, I would be in a position to make recommendations about how the quality of care could either be improved or maintained at a satisfactory level.

Question 45. One of my concerns in the area of mental health care is that veterans with mental illnesses, particularly severe and chronic conditions, are often unable to advocate for themselves and are not effectively represented by any advocacy organizations. Thus, their issues of concern in the area of health care are not presented to either the Administration or the Congress with the same frequency or effectiveness as are other issues relating to VA health care. Unfortunately, the result is that these veterans' health and mental health care needs are sometimes given short shrift. How will you ensure that the interests of chronically mentally ill veterans are identified and adequately addressed?

Response. It is my understanding that Secretary Brown has been quite committed to veterans with severe and chronic mental illness. I anticipate being similarly committed. Clearly, these individuals are not able to advocate for themselves, and their needs must be advanced by the Department's leadership.

Question 46. I introduced, and the Senate passed, S. 1512, which would establish up to five centers of mental illness research, education and clinical activities (MIRECCs) at existing VA health care facilities. The Senate Appropriations Committee has approved $1 million for FY 1995 to establish these centers. What is your view of the MIRECC proposal?

Response. I have not yet had sufficient opportunity to study the Mental Illness Research Education and Clinical Activities proposal, but I look forward to learning more about it.

Question 47. Although VA officials have consistently stated in recent years that providing needed care and services to veterans suffering from PTSD is a high priority, additional funding for specialized PTSD services has not been requested. Chronic waiting lists for treatment—and even for initial screening—persist at specialized VA PTSD programs. The most recent report of the VA's Special Committee on PTSD found that veterans were waiting as long as 5 months to be screened and another 13 months for admission to treatment. This situation is totally unacceptable.

Question 47A. Please describe the priority that you believe VA should place on providing care to veterans with PTSD and how you would ensure that priority is manifested in budget requests and programmatic planning.

Response. I believe that the diagnosis and treatment of post traumatic stress disorder and related research and educational activities are, and should remain,

a priority for the VA. I understand that improvement of services for PTSD is one of Secretary Brown's priorities in the FY 1996-2000 strategic plan. As far as recommending other things that might or should be done, I will have to defer this response until I have had an opportunity to sufficiently study what is currently being done, its effectiveness, and the most productive activities that might be pursued in enhancing existing efforts.

Question 47B. What is your assessment of the unmet treatment needs among veterans with PTSD?

Response. I am advised by VA staff that there are substantial PTSD treatment needs and that not all veterans with this condition seek treatment. Clearly, efforts to meet these needs should be a priority of the Department of Veterans Affairs.

Question 47C. How would you address the chronic waiting lists and long waiting times for treatment at specialized PTSD inpatient units?

Response. I would defer answering this question in detail until I have had sufficient opportunity to study the issue. In general, I expect that a combination of expanded treatment program capability and improvement in program coordination would serve to decrease the numbers of veterans on the waiting lists.

Question 48. Do you believe that a combat-theater veteran who has been diagnosed by a VA mental health professional as suffering from PTSD related to combat service should await formal adjudication on the issue of service connection before receiving VA treatment on a priority basis for this disorder?

Response. Although I am not yet sufficiently knowledgeable about eligibility rules and the nuances attendant to such to give a fully informed response to this question, my initial reaction is that the treatment of a combat veteran with a diagnosis of PTSD should not be delayed for administrative reasons.

Question 49. The Committee has heard from many Persian Gulf War veterans that their mysterious ailments are frequently misdiagnosed by VA medical staff as psychological illnesses, particularly PTSD. Veterans are being told that their physical ailments are "all in their heads." Despite efforts to address this problem, a recent NIH workshop on the Persian Gulf syndrome, cosponsored by VA and other federal agencies, released a report that claimed that PTSD may be causing the physical symptoms experienced by Persian Gulf veterans. This conclusion was based on a Department of Defense psychiatrist's presentation that the Persian Gulf syndrome must be a "new strain" of PTSD.

Question 49A. What is your professional view of this claim?

Response. I am aware of the controversy attendant to the "Persian Gulf War Syndrome," and, at this time, I do not feel that I am sufficiently knowledgeable about this issue to express an opinion in this regard. I would note, however, that as a medical toxicologist and as a public health official that has been involved in the management of numerous chemical disaster incidents, that there are many things about these environmental exposures that medical science does not fully understand. My general approach in this regard would be to provide for the needs of the individuals in as reasonable a way as possible, recognizing that it may take many years or decades for medical science to answer the difficult questions that exist in this regard.

Question 49B. What specific actions will you take to further educate VA medical staff about Persian Gulf syndrome? about PTSD?

Response. Again, at this time, I would defer espousing a particular course of action until I have had the opportunity to become familiar with what the Veterans Health Administration is currently doing to educate the VA medical staff about the Persian Gulf War Syndrome, as well as PTSD. I do believe that more research is needed in this regard and that this would be an appropriate area for the VA, in concert with other agencies, to pursue research if funding for such were available.

Question 50. The National Vietnam Veterans Readjustment Study released in 1988 found that African American and Hispanic veterans suffered from PTSD at a disproportionately high rate compared to their white counterparts. Specifically, the prevalence of PTSD was 27.9 percent among Hispanics, 20.6 percent among African Americans, and 13.7 percent among whites/others. Preliminary studies indicate that other minority groups have disproportionately high rates of PTSD, as well. The Vietnam Veterans Project (Matsunaga Study) is looking at PTSD among Vietnam veterans of Asian, Pacific Islander, Native American, and Native Alaskan descent.

Question 50A. What is the status of this study?

Response. I am advised by VHA staff that at least preliminary results from this study should be available sometime within the next year.

Question 50B. What efforts can be made to address the specific needs of minority veterans who suffer from PTSD?

Response. Treatment for PTSD, as well as treatment for other conditions, must be culturally appropriate. Treatment for PTSD must be sensitive to the disparate backgrounds that individuals from minority communities may have. As far as specific efforts that might be pursued to address the needs of minority veterans who suffer from PTSD, I would defer response to this until I have had time to become familiar with what the VHA is currently doing, the unmet needs, and the alternatives for enhancing such efforts.

Question 51. Please describe your views as to the needs for mental health care among veterans in general and for PTSD treatment in particular.

Response. Based upon my personal experience with the VA, as well as input from VHA staff, I understand that there are substantial mental health care needs for veterans. This seems to be particularly so in the case of substance abuse, PTSD, and chronic mental illness. Obviously, I will want to evaluate these needs further if I am confirmed.

Question 52. President Clinton and Secretary Brown have made a strong commitment to address the needs of homeless veterans. What is your view of VA's obligation to assist homeless veterans.

Response. I support President Clinton's and Secretary Brown's commitment to homeless veterans, and I hope that we can enhance our efforts to provide eligible homeless veterans with medical treatment that they need, as well as other assistance that may help them lead more productive and healthier lives. I will be especially interested in learning more about potential partnerships and sharing relationships that might be pursued with the Department of Housing and Urban Development and the Social Security Administration.

Question 53. What effort will you make to encourage the coordination of VA's homeless programs with other federal, state and community programs?

Response. Clearly, the VA's homeless programs must be coordinated with the efforts of other federal, state, and local programs. I will defer recommending specific actions in this regard until such time as I have had an opportunity to evaluate the effectiveness of what is currently being done and an opportunity to review the alternatives for how such efforts could be improved.

Question 54. It appears likely that the Department of Housing and Urban Development will receive nearly $700 million in increases in funding for homeless programs for FY 1995, of which VA homeless programs will likely receive $9 million. How can VA ensure that homeless veterans programs receive a proper share of HUD's homeless assistance.

Response. I believe that Secretary Brown has provided exemplary leadership in assisting homeless veterans. Obviously, I will be supportive of his efforts, and expect to work with my counterparts in other federal agencies to ensure that collaboration and coordination of services is achieved.

Question 55. Under health care reform, VA medical centers will be under increasing pressure to focus their resources on providing high quality, competitive medical care. However, many services that VHA provides, including care for homeless veterans, are not likely to generate third-party reimbursements or copayments. In a competitive health care market, there will be attempts to remove or "streamline" these programs. How do you intend to protect homeless programs from such severe budget pressures?

Response. Programs dealing with the homeless and other indigent populations are primarily the responsibility of the government. The government has an obligation to provide essential services for these individuals.

Question 56. Please give your general view of the Readjustment Counseling Service and its role within VHA.

Response. I understand that Readjustment Counseling Services are provided through more than 200 community-based centers that are located in all fifty states, Puerto Rico, the District of Columbia, the Virgin Islands and Guam. The mission of these centers is to provide community outreach and counseling to veterans to assist them in resolving war related psychological difficulties, including post-traumatic stress disorder, and to help veterans attain a successful post-war family and employment adjustment. This mission is integral to VA's overall responsibility in addressing the needs of veterans.

Question 57. What role do you see for the Vet Center program under health care reform? Please discuss your view of a proposal to provide basic medical care screening and referrals at the Vet Centers.

Response. The role of Vet Centers under health care reform will depend on what sort of health care reform is achieved. Absent a specific proposal, it is impossible to outline any particular changed role.

The Vet Centers seem to be well positioned to serve as major points of marketing, communication of information, and intake and referral for the VA health care system. I look forward to reviewing these opportunities and how they might be made more effective.

Question 58. The Farsetta Report recommends eliminating the RCS regional office structure, which would effectively place the Vet Centers under local medical center control. What is your view of eliminating the RCS regional offices, and how would the Vet Centers be affected by being placed under medical centers?

Response. I have not yet formulated a specific view or position on how the Vet Centers would be best organized and whether there is an advantage to eliminating the RCS regional offices. Obviously, I would like some time to assess this issue in detail.

Question 59. What plans do you have to appoint a new Director of RCS?

Response. It is my understanding that a national recruitment is underway for a new Director of RCS. As the Search Committee proceeds with its work, I look forward to reviewing candidates whose names are advanced by the Search Committee. I would hope to make a selection in a timely manner.

Question 60. Would you agree to discuss with the Committee any plans for reorganization affecting, or personnel changes in, RCS well in advance of implementation?

Response. While I have not reviewed the proposals to change the structure of the Readjustment Counseling Program, I would be happy to discuss any major organizational changes with the committee in advance of implementation of such a proposal.

Question 61. Veterans who suffer from substance abuse problems are characterized by high rates of poverty, homelessness, unemployment, mental disorders, AIDS, and hospitalization. Some reports claim that substance abuse is the nation's number one health problem. In February 1994, the Administration released its *National Drug Control Strategy*. I was unable to find any mention of VA in the document, despite the fact that VA is the largest single provider of substance abuse treatment in the country. The Administration's FY 1995 budget requested an overall increase in federal funding for substance abuse treatment programs of 14.3 percent ($360 million). VA received only a 3.5 percent increase. What efforts do you plan to make to include VA in this strategy, particularly the receipt of additional funding?

Response. I agree that substance abuse is one of the top, if not the number one, public health problem confronting the nation. I also understand that substance abuse is one of the most frequent diagnoses among veterans receiving services from VA medical facilities. I am advised that the FY 1995 appropriation for the VA treatment of drug abuse problems is $356 million and that this will support continuation of the program at current levels. Any expansion of this program in the future will depend upon procurement of new funding or the redirection of existing funding from other priority programs. At this time, I feel a need to evaluate what the VA is currently doing before espousing recommendations for changes.

Question 62. What is your view on inpatient vs. outpatient treatment for substance abuse? On the length of treatment?

Response. I believe that both inpatient and outpatient modalities need to be available for treatment of substance abuse, and that treatment for this condition must be individualized. I further understand that even with the best of treatment there will be a significant rate of recividism.

Question 63. I understand that you have had a significant amount of work in the area of AIDS. What is your assessment of VA's programs to treat those veterans suffering from AIDS?

Response. Yes, I have been involved with AIDS in a number of ways. I was very much involved in the development of California's $100 million-plus state AIDS program while I was with the Department of Health Services. I have continued my involvement with this condition in a number of ways since leaving state government.

While I have been advised that the VA has a well-established, integrated program of clinical care, education and research for the treatment of HIV disease, I will defer judgment about the effectiveness of the VA's program until I have had more direct contact with it.

Question 64. What can VA learn from other AIDS care providers, in terms of alternatives to traditional bed care and treatment programs?

Response. AIDS has shown us that with new technologies and with better prophylactic care, affected persons can be kept functional for longer periods of time after becoming ill and that they can decrease their need for inpatient care. The need for less inpatient care can be particularly demonstrated when there is adequate home and convalescent care of various types.

Question 65. Would you attempt to secure general funds to improve the provision of AIDS care in VA, such as grants from the Ryan White Foundation?

Response. In general, I would look to secure funds to support VA programs for AIDS (as well as other conditions) from any and all legitimate sources of funding. I am aware of the intense competition for the Ryan White Act funds, but I see no reason why the VA should not be a competitor for these funds.

Question 66. What is your assessment of VA's advances in the field of telemedicine, and what is your view of the potential of telemedicine to link rural VAMCs with larger, more integrated VAMCs?

Response. I am a strong supporter of telemedicine, and I believe that it offers myriad opportunities to link rural and urban health care facilities. I am not fully aware of what the VA is doing in this regard, and I look forward to learning more about it. I anticipate being very supportive of these efforts, as I have been in the last three years at the University of California, Davis.

During the last three years, I have been a member of the Telemedicine Planning Committee at the University of California, Davis. This committee has promulgated a plan for UC Davis to be a telemedicine provider for inland Northern California. As you may know, inland Northern California is very rural and has immense areas of very low population density.

One specific thing in this regard that I would note is that recently I was awarded a contract by the San Francisco Superior Court to establish a clinic for the medical surveillance of the Sacramento River Spill victims. As you may know, in July 1991, a Southern Pacific Railroad tanker car derailed at Dunsmuir, spilling thousands of gallons of the herbicide metam sodium into the Sacramento River and effectively sterilizing forty miles of the river before it flowed into Shasta Lake. Consequent to that spill, many individuals reported health problems related to herbicide exposure, and this has been a subject of

ongoing litigation. As part of the court ordered settlement of an action brought against Southern Pacific, a fund was established to support a clinic to monitor health effects that might be related to the spill. A colleague and I were asked to direct this clinic. One of the things that we have planned for this clinic is a telemedicine linkage with the UCD Medical Center, some 250 miles away. We hope to provide online consultative services to the Dunsmuir community. This linkage is not yet established, but we are hopeful that it will be within the next year.

Question 67. By the year 2000, over 60% of the entire U.S. male population over 65 will be veterans.

Question 67A. Some outside experts have argued that VA long-term care is often underfunded relative to non-VA long-term care. What is your view of this?

Response. It is my general impression that long-term care is underfunded by everyone. As far as making a direct comparison between VA and non-VA sponsored long-term care, I will have to defer my response to this until I have had an opportunity to assess the issue in detail.

Question 67B. What is your general view of VA's role in geriatrics and gerontology?

Response. I have been highly supportive of geriatrics and gerontology during my career. Indeed, at the University of California, Davis, my department operates the Center for Aging and Health, as well as two Alzheimer's Disease Centers. During my tenure with the California Department of Health Services, I was instrumental in achieving increased funding for the Alzheimer's Disease Centers, as well as increased funding for other senior programs.

I believe that geriatrics and gerontology are very important to the VA, and that the VHA has already established a leadership role in this regard. The VA should continue to be a leader in aging and geriatrics issues.

Question 67C. What ideas do you have for making long-term care a real priority in VA?

Response. Long-term care has to be a priority for the Veterans Health Administration. There will be an increasing need for long-term care treatment capability in the future. I would defer espousing a particular plan for enhancing the VA's long-term care capability at this time, pending a review of what it is currently doing and the alternatives for enhancement of these efforts.

Question 68. What are your views about VA-community joint ventures, especially with regard to Alzheimer's disease facilities?

Response. As I noted in my responses to previous questions, I believe that VA joint ventures can be mutually beneficial. I can certainly see where this would be the case with the Alzheimer's disease facilities. In looking at these joint ventures, though, I would again underscore the essentiality of ensuring that any sharing program not detract from the care provided to veterans.

Question 69. What are your views on the Geriatric Research, Education and Clinical Centers?

Response. I am supportive of the Geriatric Research, Education and Clinical Centers program. I believe that this is an important resource for both the

Veterans Health Administration and the nation. I am also supportive of innovative long-term care programs such as Adult Day Health Care, Hospital-Based Home Care and Respite Care. As you may know, many of these models have been pioneered in California. Indeed, programs like On-Lok in San Francisco, which was supported by my Department when I was state health director, has been widely viewed as a model of alternative nursing home care.

I anticipate that I would be supportive of the VA's efforts to develop programs of this type, but I would defer making specific recommendations in this regard until I have had a chance to review what the VA is currently doing and the alternatives it has in this regard.

Question 70. What are your views on VA's efforts to date to expand traditional long-term care to include alternatives to nursing home care such as Adult Day Health Care, Hospital-Based Home Care, and respite care?

Response. I have been advised that within the past several years, VA has expanded long-term care to include several alternatives to nursing home care. I am told that 83 medical centers contract for adult day health care and 100 medical centers for homemaker and home health aide services. Hospital-based home care is currently provided at 78 medical centers. I am advised that these have proven to be valuable and popular long-term care programs.

Question 71. PTSD treatment, blind rehabilitation, and spinal cord injury care are among VA's most attractive programs for veterans seeking medical and mental illness treatment. Could these programs be a selling point for VA under health care reform? If so, what efforts will you make to ensure that medical center directors protect, if not enhance, such programs?

Response. I would concur that PTSD treatment, blind rehabilitation and spinal cord injury have been strengths of the VA health care system, and that these strengths should be capitalized upon by the VA as it enters a competitive health care environment.

Question 72. What is the VA's role in ensuring that men and women who serve in our nation's military are protected from toxic exposures which might ultimately harm them?

Response. I believe that the VA should work with relevant entities in the Department of Defense, and other agencies, to help ensure that our Armed Forces are protected from toxic exposures. The VA seems to be well positioned to assess the long-term consequences of low level exposures. As a medical toxicologist, I have particular interest in the VA's activities in this regard.

Question 73. Persian Gulf War veterans frequently report that they are unable to have their claims adjudicated quickly because their service and VA medical records are lost. What possible solutions might you foresee so that pertinent medical information is available for quick retrieval for veterans?

Response. I have not studied this issue, and so I would defer offering any potential solutions until I have had the opportunity to become more familiar with it. It appears to me, however, that utilization of electronic medical records and similar technologies may provide some benefit in this regard. Indeed, the Veterans Health Administration may be a particularly desirable arena to pilot the development of electronic medical records and related technology.

Question 74. The Committee is currently hearing reports that the children and spouses of Persian Gulf War veterans may have health problems related to their service member's participation in Desert Storm/Desert Shield. How could the VA verify if such reports are accurate, given the fact that VA does not provide care to dependents or research service-connected disorders that might affect spouses and children?

Response. I have heard some reports along the lines that you mention about family members of Persian Gulf War veterans attributing their health problems to the service member's participation in Desert Storm, and I understand the difficulties in establishing scientifically sound responses to these complaints. I have been apprised that the VA has established a Persian Gulf family support program and that it is making other efforts to assess these problems. I would defer making specific recommendations at this time, pending my review of what is currently being done and the alternative actions that might be taken.

Question 75. The Committee is being contacted by Persian Gulf War veterans who are unaware of the VA Persian Gulf War Health Registry. Please describe an outreach plan whereby all veterans who served in the Persian Gulf would receive timely information regarding the health consequences of serving in the Persian Gulf, and information about the registry.

Response. Information about the VA Persian Gulf War health registry should be widely disseminated using the assets of the Veterans Benefits Administration, the veterans service organizations, the Department of Defense, the American Red Cross, the Vet Centers, the National Guard and Reserve, the U.S. Postal System, and both electronic and print media.

Question 76. Please also describe how VA physicians might receive updated information on the health consequences of service in the Persian Gulf.

Response. Multiple modalities should be utilized to inform VA physicians about the health consequences of service in the Persian Gulf. Among the specific vehicles that might be used are video teleconferences, newsletters, "all hands" mailings, special workshops, Grand Rounds presentations, posters and presentations at national medical conferences, and publications in peer reviewed scientific journals. In addition, appropriate posters and signage might be developed that would facilitate understanding and recognition of the issues here.

Question 77. Concerns frequently have been raised about the number of VHA examinations that cannot be used for purposes of a compensation or pension claim. The VA Blue Ribbon Panel on Claims Processing, established in June 1993 by then-Deputy Under Secretary for Benefits, R. John Vogel, found that VHA physicians routinely fail to use the VA Physician's Guide in conducting compensation and pension (C&P) examinations. The Panel's report further indicated that "because of time pressures, VBA often accepts examination reports for rating purposes that do not comply."

The Panel's proposed solutions and actions included the following: (1) expansion of the current VBA/VHA Memorandum of Understanding (MOU) to include quality measures for C&P exams; (2) establishment of a reporting scheme to monitor quality, both locally and nationally, (3) establishment of physician's coordinators at the VA Central Office, VAMCs, and regional offices; (4) establishment of a joint VBA/VHA education and training effort on C&P exams; (5) improvement of the Automated Medical Information Exchange

(AMIE); and (6) transfer of the responsibility and resources for C&P exams from VHA to VBA.

Question 77A. According to VBA's plan for implementing the recommendations of the Panel, provided to the Committee by Mr. Vogel on March 24, 1994, action should have begun on all of these recommended initiatives, and should have been completed on some of them. Please indicate the current status of the implementation of each of these initiatives and your plans for further coordination with the Under Secretary for Benefits for purposes of complete implementation of the Panel's recommendations.

Response. See 77C.

Question 77B. Please provide your views as to the effectiveness of AMIE with respect to the coordination between VHA and VBA concerning compensation and pension examinations.

Response. See 77C.

Question 77C. In addition to the actions currently being taken on the recommendation of the Blue Ribbon Panel, what additional initiatives, if any, would you seek to pursue, to improve the coordination between VHA and VBA concerning C&P exams, in an effort to promote timely adjudication of benefit claims?

Response. I am sorry, but I have not yet had a chance to become familiar with the Panel's report, so I am not in a position to comment on the status of the recommendations, nor to espouse additional recommendations. I would note, however, that I see the Under Secretary for Health's role as one of partnership with Mr. Vogel in efforts to improve service to veterans making a claim for compensation or pension benefits. I am apprised that there are a number of joint projects and work groups addressing these issues, and I look forward to learning more about this process.

Question 78. Please provide your views on allowing the use of a private physician's examination report in lieu of the requirement for a VA examination.

Response. In principle, I see no reason why a private physician's report should not be allowed if it contains the appropriate information needed to make the determination. This is an area that I will need to further investigate.

Question 79. How do you react to the suggestion that C&P exams be done in regional offices and by VBA employees? In other words, the examiners would be VBA employees who would be stationed in regional offices.

Response. Again, as noted above, I do not believe that I have sufficient information, at this time, to make an adequately informed response to this question. In general terms, it certainly makes sense from an access and cost standpoint to provide exams at a location close by a veteran's home or workplace. However, in some cases, it may not be possible to get the necessary specialty exams or ancillary services locally, and this might preclude the use of VBA facilities. Obviously, this is an issue that I need to review in depth with Mr. Vogel.

Question 80. What is the timeliness standard for processing compensation and pension exams and returning the claims to the regional office?

Response. I am advised that the present timeliness standard for processing compensation and pension exams and returning the claims to the regional office is 35 days.

Question 81. How did VHA determine the appropriate standard and what role did VBA play in this determination?

Response. I understand that the current standard is a 33% reduction from the prior standard of 52 days. Obviously, I was not a part of that decisionmaking process so I cannot comment on exactly how the decision was made, but I have been advised that it was a joint decision between the VBA and VHA.

Question 82. How many medical centers meet these standards?

Response. I am advised that for the month of June 1994, 92% of facilities met or exceeded the standard, although I do not have independent information in this regard.

Question 83. Are there any common characteristics among VAMCs that have low timeliness compliance rates, such as urban or rural location, facility size, or distance between the regional office and the VAMC that services the regional office?

Response. Again, I do not have independent information in this regard, but I have been advised by VHA staff who have looked at the most recent report that there are no unifying themes or commonalties among the facilities that have low timeliness compliance rates.

Question 84. Are you satisfied with the timeliness of VHA's performance of C&P exams?

Response. At this time, I am not sure whether I should be satisfied with the timeliness of VHA's performance of compensation and pension exams. It is my general experience that there is always room for improvement, and I would hope that we can further improve on the timeliness of this process. However, I need to further investigate this issue.

Question 85. Please describe your personal record in the Equal Employment Opportunity (EEO) field during your career.

Response. I have always strongly supported Equal Employment Opportunity programs, and I have been a strong advocate for achieving diversity in the workforce. During my tenure as Director of the California Department of Health Services I received numerous letters from employees complimenting efforts that were undertaken in this regard and for my personal involvement in the EEO process. I also received an award from the Black Advocates in State Service for my efforts on their behalf.

As Director of the California Department of Health Services, we did pioneer some new programs, especially as related to improving the representation of Hispanics in our state workforce. (This was the most underrepresented target group.)

One of the difficulties that we confronted in diversifying our workforce at the Department of Health Services was a need for technical and scientific personnel, yet there is substantial underrepresentation of women and minorities in scientific and technical fields. We embarked on a widespread recruitment effort and were gratified by the response, although government often lost out

to the private sector because of the higher salaries and better benefits in the private sector. Overall, during my tenure at the Department of Health Services we more than doubled the percentage of disabled and Hispanic persons in our workforce, and we made substantive gains towards achieving parity in other targeted groups.

Question 86. Have you ever been the subject of an EEO complaint of any type and, if so, was (were) such complaint(s) resolved, and how?

Response. As the Director of the California Department of Health Services, I was named in my official capacity in various complaints against the state; however, I am not aware of any such complaints that were ever upheld. In one particular case a group of six African-American males sued the state alleging that the Department discriminated against black males over the age of 40 based on their failure to be promoted on a mid-level management civil service examination. And while I was in no way involved in that examination process, I was named in the suit because I was the Director. Ultimately, the matter went to trial, and an ethnically mixed jury denied all claims of the complainants, finding for the state on 13 out of their 13 claims.

Question 87. Have you in the past received or are you now receiving any VA benefits? If so, please describe any such benefits.

Response. I currently do not receive any VA benefits. From about July 1980 through December 1981, I received VA educational benefits while I was pursuing postgraduate training at the University of California, San Francisco.

Question 88. Who assisted you with the preparation of these responses?

Response. Information for draft responses was gathered for me by the Office of the Chief of Staff to the Under Secretary for Health. Staff in the offices of the AsCMD for Clinical Programs, Research and Development, Operations, Academic Affairs, Quality Management, Administration, and the Chief Financial Officer, as well as the offices of General Counsel and Congressional Affairs, assisted in preparing the responses.

WRITTEN QUESTIONS FROM SENATOR AKAKA TO DR. KIZER AND THE RESPONSES

Question 1. Dr. Kizer, the 173 medical centers that comprise the VA health care system have sometimes been accused of being autonomous fiefdoms, their preservation of the bureaucracy is stressed at the expense of innovation and improving services for veterans. If there is some truth to this, what are your plans to ensure that local medical center directors are made accountable to you and to veterans in general?

Response. I hope to initiate a VHA culture that is focused on quality, innovation and user satisfaction. To be competitive, the VA must provide high quality, state-of-the-art service that makes its beneficiaries want to continue receiving their care from the VA. This will require new ways of thinking in some cases, as well as new ways of doing business. I hope that I can set a course for the VA such that it will be the health care provider of choice for veterans. One of the responsibilities of the VA Central Office will be to provide the tools and guidance needed by field managers. I plan to hold

managers at all levels of the organization accountable for both the successes and shortcomings of their efforts.

Question 2. Do you believe that the quality of VA health care is comparable to that provided by private sector care? Please explain what you base your opinion on.

Response. I have not yet had a chance to review VHA's data regarding the system's overall quality of care, so I will defer judgment on such for the time being. However, based on my personal experience, I believe that the quality of care provided in VA facilities compares favorably to the private sector.

Question 3. Regardless of the actual quality of the services provided by VA, there is a *perception* in some quarters that VA health care is not equal to that provided in the private sector. No doubt these perceptions are fueled in large measure by highly selective media coverage that focuses on VA shortcomings rather than its successes. Would you expect this negative perception to affect VA's ability to compete against private health care providers (e.g., under the Clinton health care plan)? Do you have any thoughts on how VA's image could be improved?

Response. Yes. Focusing on the VA's image is highly important and will be one of my top priorities. To be competitive, the VA must have a good image. To have a good image, the VHA will have to provide readily apparent superior quality health care at a reasonable cost.

Question 4. The Readjustment Counseling Service (RCS), or vet center program, has always been something of a stepchild service. Since its inception fifteen years ago, attempts have been made to place vet centers physically within medical centers and administratively under the control of the local chiefs of staffs. Recognizing that vet centers have a unique mission, Congress has regularly blocked such attempts. In fact, legislation which I have introduced to preserve RCS's administrative independence has passed the Senate. What are your general views about the services provided by vet centers? What are your thoughts regarding the need to preserve the administrative and clinical independence of vet centers vis-a-vis medical centers?

Response. I do not come into the VA with a preconceived view of how the Readjustment Counseling Service (i.e., vet centers) and VA medical centers should relate or be organized. The most important thing to me is that they do the job for which they were established.

Question 5. As you know, the directorship of the vet center program is vacant, and a candidate selection process is now underway. Because the program has had only two directors, neither of whom had actual field experience as an RCS employee, I have proposed that VA seriously consider selecting future directors from within the vet center program. Not only would this ensure that the program is headed by someone familiar with the program, it would also improve morale in the field by effectively opening up the top job to career vet center employees. As Under Secretary, you will approve the next director. How much weight will you give to a candidate's experience in the vet center program, particularly at the local level? How much of an effort will you make to ensure that qualified minorities and females are considered?

Response. I am advised that the national recruitment effort that was begun some time ago has identified a culturally diverse group of qualified candidates

who all have RCS field experience. I will review candidates whose names are advanced by the search committee being mindful of your concerns.

Question 6. Historically, the VA health care system has been designed to meet the needs of veterans who are male and Caucasian. The special needs of minorities and women have not always been accommodated. What are your thoughts with respect to addressing the needs of minorities and women? What will you do to encourage VA to focus on their concerns?

Response. Women veterans and ethnic minority veterans should expect no less quality of care nor any less sensitivity to their needs than male Caucasian veterans. I have been advised that the VHA has made significant progress in meeting the needs of women veterans in recent years, but I also have heard that further improvement is needed. Likewise, I have been advised that a number of efforts are underway to recognize and respond to the special needs of ethnic minority veterans. I will defer espousing any specific plans for action in these areas until I have had an opportunity to evaluate what is currently being done and where such efforts could be enhanced. In this regard, I welcome the input of VA's advisory committees and the Department's Chief Minority Affairs Officer.

Question 7. Hawaii is only one of two states without a VA medical center. After many years of delays, it now appears that a VA hospital will be built in the Aloha State before the next century. How committed are you to establishing this facility?

Response. While I have not yet had a chance to review VA's construction programs, or any of the specific proposed projects, I have been apprised of the longstanding commitment to establish a VA facility in Hawaii.

Question 8. The absence of a VA hospital in Hawaii is but one manifestation of historical lack of access to VA services and benefits for veterans located in rural or remote areas. American Samoa is an example where there is a significant veterans population which has little access to VA services. What are your views with respect to the obligation of VA to provide equal access to VA treatment for veterans in rural or otherwise isolated areas?

Response. I have not yet had the opportunity to be briefed on VA's efforts to provide care to veterans who reside in rural or isolated areas. I am aware that various mechanisms are used in such cases, and I look forward to reviewing current and planned activities in this regard.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO DR. KIZER AND THE RESPONSES

Question 1. Dr. Kizer, how do you envision VA competing if Congress adopts some form of National Health Care?

Response. The manner in which the VA will compete with other health care providers, should Congress adopt some form of national health care, will depend on the type of reform that is adopted. If some form of national health care is adopted, the needs of the veterans health system will need to be addressed in the legislation if the VA is to have a reasonable chance of successfully competing in the health care environment of the 21st Century. Important to note, however, is that the VHA needs to change the manner in

which it provides health care based simply on the merits of the needed change. The economics of health care, new technologies and methods of treatment, and changing social and demographic characteristics of VA beneficiaries, among other things, necessitate change regardless of what Congress enacts in the way of national health care reform. Among the changes that the VA needs to pursue in order to be competitive is the development of local and regional integrated networks of care having strong ambulatory and long term care components and which emphasize user (i.e., patient) satisfaction.

Question 2. Dr. Kizer, for the record, please provide the annual salary that you will receive as Under Secretary for Health.

Response. The Secretary has approved a total salary level of $179,600. This level includes $123,100 base pay and $56,500 special pay.

WRITTEN QUESTIONS FROM SENATOR THURMOND TO DR. KIZER AND THE RESPONSES

Question 1. In your response to a question on quality management, you discussed a total quality management program you implemented in California and described improvements in administrative processes. In connection with this, first, would you comment on your assessment of the current quality of VA health care and what improvements might be implemented; and second, what is the status of the monitoring program for resident supervision, which resulted from a 1992 GAO Audit recommendation?

Response. I will need to study VHA's quality of care data and become more familiar with individual institutions before I make a personal assessment of the quality of VA health care. However, as with any large health care system, I expect that there is a range of quality of care provided at individual VHA institutions. I believe that outstanding care is provided at some VA facilities, while average care is provided at others, and I would be surprised if some facilities did not need to improve their quality of care. I have not yet had an opportunity to review the 1992 GAO audit recommendations regarding resident supervision. I am mindful, however, of the importance of residence supervision.

Question 2. VA and academic affiliations are an important part of the VA health system, as you recognized in your prepared responses. What concerns do you have on possible conflicts of interest that may arise as a result of dual employment situations where a VA employee may also be employed by the affiliated medical school? Do the Federal Ethics requirements need to be strengthened in this regard?

Response. At the present time, I am not aware of any notable conflict of interest problems involving staff/faculty who have joint VA and affiliate medical school appointments. Overall, these arrangements seem to have been advantageous to VHA over the years.

Question 3. The debate on national health care reform has produced mixed opinions on whether veterans will come into a VA health plan or will choose non-VA plans. I have a two-part question: (a) What will you do to ensure that a declining patient base will not threaten the quality of care? (b) Conversely, there is some concern that under a system where a part of co-payments or third-party reimbursements are available to the medical centers, that these income producing patients may squeeze out non-revenue producing patients.

What policy would be implemented to ensure that VA medical centers will continue to give appropriate recognition and treatment to priority categories of veterans?

Response. Positioning VHA to be the provider of choice for veterans will be one of my top priorities. To do this will require that the services provided to veterans are easily accessible, compassionate, responsive to their needs, and of superior quality. Specific strategies that might be pursued to deal with the effects of national health care reform will need to be looked at within the context of the specific reform scenario.

QUESTIONNAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Name: KIZER (LAST) KENNETH (FIRST) WAYNE (OTHER)

2. Present address: 3740 Clover Valley Road Rocklin, CA 95677 (CITY) (STATE) (ZIP CODE)

3. Position to which nominated: Under Secretary for Health Department of Veterans Affairs

4. Date of nomination: July 29, 1994

5. Date of birth: 28 May 1951 (DAY) (MONTH) (YEAR)

6. Place of birth: Decatur, Indiana, USA

7. Marital status: Married

8. Full name of spouse: Suzanne Arlene Kizer

9. Names and ages of children: Kelly Christina Kizer-16
Kimberly Casey Kizer-14

10. Education:

Institution (including city and State)	Dates attended	Degrees received	Dates of degrees
Stanford University Stanford, California	9/68-6/72	Bachelor of Science	June 1972
University of California, Los Angeles	9/72-6/76	Doctor of Medicine	June 1976
University of California, Los Angeles	9/73-6/76	Master of Public Health	June 1976
Naval Regional Medical Ctr. Portsmouth, Virginia	7/76-6/77	Internship Anesthesiology	June 1977
Naval Undersea Medical Inst. Groton, Connecticut	7/77-12/77	Undersea Med. Officer Course	Dec. 1977
University of California, San Francisco	7/80-12/81	Radiology Residency	Dec. 1981
University of California, San Francisco	7/82-6/83	Occupational Medicine Residency	June 1983

11. Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

See attached Curriculum Vitae (appendix 1), pages 4-6

12. Memberships: List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and any other prior memberships or offices you consider relevant.

Organization	Office held (if any)	Dates
See attached Curriculum Vitae (Appendix 1), pages 6-13		

13. Employment record: List below all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment.

See attached Curriculum Vitae (Appendix 1), pages 47-52

14. Military service: List below all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge.

United States Navy, Honorable Discharge

See attached Curriculum Vitae (Appendix 1), pages 51-52

15. Government experience: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than those listed above.

See attached Curriculum Vitae (Appendix 1), pages 10-12

16. Published writings: List the titles, publishers, and dates of books, articles, reports, or other published materials you have written.

See attached Curriculum Vitae (Appendix 1), pages 14-46

17. Political affiliations and activities: (a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years.

NONE Republican Party - 1988 (about $100) and 1989 (about $100). Miscellaneous small contributions (approx. $10-$100) to both Republican and Democratic candidates, including Art Agnos, Democratic candidate for Mayor of San Francisco in 1987 (about $100) and George Deukmejian, Republican candidate for Governor of California in 1986 (about $100). No record has been maintained of these.

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved.

Rocklin School Board, November 1985

18. Future employment relationships:

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate.

Yes, although I may maintain a relationship with a few of the nonprofit, community benefit organizations.

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization.

None

(c) What commitments, if any, have been made to you for employment after you leave Federal service?

None

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed?

Yes

(e) (If appointed for an indefinite period) Do you intend to serve until the next Presidential election?

N/A

19. Potential conflicts of interest:

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated.

None (investments are detailed in Part II)

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

None [Although I do not believe there is any conflict of interest, I would note that I have been a faculty member at the University of California, Davis (UCD), for the past three years, and UCD and other University of California campuses have longstanding and on-going relationships with various VA medical care facilities in California.]

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy.

None [I would note that during my tenure as Director of Health for the State of California 1985-1991, I met with various federal officials on legislation and administrative policy. No specific record of such meetings, correspondence, etc., has been maintained. However, I am providing the Committee with a listing of Congressional and State Legislature hearings that I can recall.]

(e) Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

N/A

20. Testifying before the Congress:

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee?

Yes

(b) Do you agree to provide such information as is requested by such a committee?

Yes

Curriculum Vitae for Kenneth W. Kizer, M.D., M.P.H.

PERSONAL
Birthdate: May 28, 1951
Birthplace: Decatur, Indiana, U.S.A.
Family: Married, two daughters
Address: Office - Department of Community and International Health, School of Medicine, TB-168, University of California, Davis, CA 95616 (916) 752-3972 (916) 752-3239 (FAX)
Home: 3740 Clover Valley Road, Rocklin, CA 95677 (916) 624-1774 (916) 624-3616 (FAX or phone)

PRINCIPAL PRESENT POSITIONS
Professor and Chairman; Department of Community and International Health, University of California, Davis
Professor, Division of Emergency Medicine and Clinical Toxicology, Department of Internal Medicine, University of California, Davis
Adjunct Professor of Public Administration, University of Southern California Chairman, Board of Directors, The California Wellness Foundation
Attending Physician, Emergency Department:
University of California, Davis, Medical Center, Sacramento Tahoe Forest Hospital, Truckee

SELECTED PREVIOUS POSITIONS
1985-1991, Director, Department of Health Services, State of California
1984-1985, Chief Deputy Director for Preventive Health Services and Chief, Public Health Programs, Department of Health Services, State of California
1983-1984, Director, Emergency Medical Services Authority, State of California
1979-1980, Group Medical Officer, U.S. Navy Explosive Ordnance Disposal Group One, Barbers Point, Hawaii
1978-1979, Squadron Medical Officer, Submarine Squadron Fifteen Representative, and Staff Physician, Navy Regional Medical Center, Pearl Harbor, Hawaii

EDUCATION
High School Diploma, Reno High School, Reno, Nevada (1968)
Bachelor of Science (with Distinction), Stanford University. Stanford, California (1972)
Doctor of Medicine (with Honors), University of California, Los Angeles. Los Angeles, California (1976)
Master of Public Health (Epidemiology), University of California, Los Angeles. Los Angeles, California (1976)
Rotating Internship (Department of Anesthesiology), Naval Regional Medical Center. Portsmouth, Virginia (1976-77)
U.S. Navy Undersea Medical Officer Course, Naval Undersea Medical Institute. Groton, Connecticut (Jul-Dec 1977)
Diagnostic Radiology Residency, University of California, San Francisco. San Francisco, California (Jul 1980 - Dec 1981)
Occupational Medicine Residency, University of California, San Francisco. San Francisco, California (Jul 1982 - Jun 1983)

MEDICAL LICENSURE AND SPECIALTY CERTIFICATIONS
Diplomate, National Board of Medical Examiners (1977)
Diplomate, American Board of Medical Toxicology (1983)
Diplomate, American Board of Preventive Medicine
Certification in Occupational Medicine (1984)
Certification in Public Health and General Preventive Medicine (1988)
Eligible to take the examination for Certificate of Added Qualification in Undersea and Hyperbaric Medicine (1992)
Diplomate, American Board of Emergency Medicine (1984)
Eligible to take the Medical Toxicology Subspecialty Examination (1994)
Eligible to take the examination for the American Board of Medical Management (1992)
Medical Licenses: California (#G41907), Washington (#17265, inactive), Hawaii (#3331, inactive)

OTHER TRAINING AND CERTIFICATIONS
Completion of the Toll Fellowship, The Council of State Governments. Lexington, Kentucky (1987)

Certified by the American College of Emergency Physicians as an Instructor for "Disaster Management and Planning for Emergency Physicians" (1983)
Completion of the Base Station Physician Course, California Chapter of the American College of Emergency Physicians (1982)
Completion of the Advanced Life Support Base Hospital Physician Training Program, Advanced Life Support Training Center. Alameda County, California (1982)
Certified as a Scuba Diving Instructor by the Professional Association of Diving Instructors (1980) and the National Association of Underwater Instructors (1982)
Completion of the U.S. Navy Medical Department Orientation Course on Alcoholism, Long Beach Naval Hospital. Long Beach, California (1979)
Completion of the Nuclear Reactor Familiarization School, Naval Nuclear Weapons Training Unit/Knolls Atomic Power Laboratory. Ballston Spa, New York (1978)
Certified by the American Heart Association as an Instructor for Basic Cardiac Life Support (1978) and Advanced Cardiac Life Support (1979)
Graduated from the U.S. Navy School of Diving and Salvage, Washington, D.C., with certification as a Navy scuba and deep-sea diver, diving medical officer, and hyperbaric chamber operator (1977)

FELLOWSHIPS AND HONORARY SOCIETY MEMBERSHIPS
Elected to Fellowship in the:
American College of Preventive Medicine (1984)
American College of Emergency Physicians (1985)
American College of Occupational and Environmental Medicine (1988)
American Academy of Clinical Toxicology (1991)
Royal Society of Health (1992)
Royal Society of Medicine (1993)
The Explorers Club (1994)

Elected to:
Delta Omega National Honorary Public Health Society (1986)
Alpha Omega Alpha Honor Medical Society (1975)

SELECTED HONORS, AWARDS AND OTHER ACHIEVEMENTS
Health Promotion Award "For Significant Contributions in the Field of Wellness and Preventive Medicine," California Association of HMO's Foundation (1994)
Award of Distinction, Toward a Tobacco Free California. California Department of Health Services (1992)
Continuing Service Award, National Association of Underwater Instructors (1992)
Special Recognition Award "In appreciation of your exceptional efforts for healthier babies", March of Dimes (1991)
Special Recognition Award "In Recognition of Courageous Public Health Leadership ...", California Conference of Local Health Officers (1991)
California State Senate Resolution for "... exemplary leadership in public health and health services delivery ..."(1
Special Recognition Award "For Outstanding Leadership and Support of the Nutrition and Cancer Prevention Program...", California Fresh Produce Council (1991)
Certificate of Appreciation for .... .Special Contribution to Operation Desert Support...", Sacramento County Pomono Grange #2 (1991)
Special Acknowledgement Award "For Helping in the Fight Against Cancer ...", American Cancer Society, Inland Empire Unit (1991)
Jean Spencer Felton Award for Excellence in Scientific Writing, Western Occupational Medical Association (1989)
Special Achievement Award "In Recognition of Outstanding Accomplishments in Emergency Medicine Education and Publication," California Emergency Physicians Medical Group (1989)
Certificate of Recognition for "Outstanding Service to the Health and Welfare of the Asian Pacific Communities," California Asian Pacific Health Coalition (1989)
Special Recognition Award for "... Support to the Implementation of the IRCA-SLIAG Program for Primary Health Care Clinics in California," California Health Federation, Inc., and Primary Health Care Clinics (1988)
Special Recognition Award for "Outstanding and Dedicated Service in the Prevention and Control of Lung Disease," American Lung Association, California Division (1988)
Selected for the Delta Tau Delta (Beta Rho Chapter) Hall of Fame (1987)
Selected as a Toll Fellow, The Council of State Governments (1987)

Special Recognition Award for ``Services to Reduce the Public Health Threat of Hypertension," Golden State Medical Association (1986)
Outstanding Contribution to Diving Award, National Association of Underwater Instructors (1984)
Special Recognition Award for "Assistance in Reducing Death and Disability to the Residents of Northeastern California," Northern California Emergency Medical Care Council (1984)
Navy League of the United States National Sea Service Award, Co-Winner of the Rear Admiral William S. Parsens Award for Scientific and Technical Progress (1980)

Military Decorations
Department of Defense Humanitarian Service Medal (1979)
U.S. Navy Meritorious Unit Commendation (1979)
National Defense Service Medal (1976)
Selected as "The Outstanding Junior Officer of Hawaii - 1979", Navy League of the United States, Honolulu Council (1979)
Special Achievement Award, Navy League of the United States, Honolulu Council (1979)
Departmental Honors Program (Biological Sciences), Stanford University (1971-72)
Youth Governor, Nevada YMCA Youth in Government Program (1968)
Outstanding Citizenship Award and Medal, Sons of the American Revolution (1968)
Winner of the Nevada Elks Club Youth Leadership Contest with National Honorable Mention in the same (1968)

CURRENT PROFESSIONAL ORGANIZATION AFFILIATIONS
American College of Physician Executives
American College of Emergency Physicians (Fellow)
California Chapter, American College of Emergency Physicians
American College of Preventive Medicine (Fellow)
American Public Health Association
American College of Sports Medicine
American College of Occupational and Environmental Medicine (Fellow)
Western Occupational Medical Association
American Academy of Clinical Toxicology (Fellow)
International Society on Toxinology
Royal Society of Health (Fellow)
Royal Society of Medicine (Fellow)
The Explorer's Club (Fellow National)
Wilderness Medical Society
Undersea and Hyperbaric Medical Society
American Academy of Underwater Sciences
National Council for International Health
American Association for World Health
Wilderness Education Association

ACADEMIC APPOINTMENTS AND SERVICE
UNIVERSITY OF CALIFORNIA, DAVIS (UCD)
Faculty Appointments
1992- Professor (Step V); Division of Emergency Medicine and Clinical Toxicology, Department of Internal Medicine
1991- Professor (Step V) and Chairman; Department of Community and International Health
1988-1992 Associate Clinical Professor; Division of Emergency Medicine and Clinical Toxicology, Department of Internal Medicine
1988-1991 Associate Clinical Professor; Department of Community Health
1985-1988 Assistant Clinical Professor; Division of Emergency Medicine and Clinical Toxicology, Department of Internal Medicine
1984-1985 Assistant Clinical Professor; Division of Occupational Medicine, Department of Internal Medicine

Selected University Service
University of California Systemwide
1986-1991 Advisory Committee for the Toxic Substances Research and Training Program
1991-1993 Academic Geriatric Resource Program Advisory Committee
1992-1994 Subcommittee on New Immigrants and Health in California's Rapidly Diversifying Population, Health Sciences Committee
1992- Lead Contamination Advisory Board (UC Extension)

University of California, Davis
1987-1991 External Review Committee, Biomarkers of Exposure to Hazardous Substances Project (a federal Superfund Research and Education Project)
1990-1991 External Advisory Panel, Agricultural Health and Safety Center
1991- Academic Senate; Representative for the Departments of Community Health, Dermatology and Family Practice
1991- Faculty Advisor, Delta Tau Delta Crescent Colony
1992- Graduate Group in Ecology
1992- Graduate Group in Epidemiology
1993-1994 Chairman, Diving Control Board
1993-1994 Animal Agriculture Impacts on Water Quality Project, Agricultural Issues Center and Animal Agriculture Research Center
1992-1993 Food-Borne Diseases Lectureship and Workshop Planning Committee, School of Veterinary Medicine UCD School of Medicine and Medical Center
1983-1985 Director, "Marine and Aquatic Sports Medicine" continuing medical education program
1991-1994 Geriatrics and Gerontology Working Group
1991- Representative to the California Medical Association's Advisory Panel on Preventive Medicine and Public Health
1991- Council of Deans and Department Chairs
1991- Clinical Practice Board, Contracts, Managed Care and External Relations Work Group (1992-) 1991- Continuing Medical Education Advisory Committee
1991-1993 Utilization Review Committee
1992-1994 Chair, Managed Care Steering Committee
1993-1994 Telecommunications Planning Committee
1992-1994 Co-Chair, Cancer Control Working Group
1992-1993 Primary Care Education Planning Committee of the Universitywide Planning Committee on Primary Care Education
1993-1994 Geographic Managed Care Executive Committee
1993- VA Dean's Committee
1994-1994 Co-Chair, Health Professions Education Work Group, Strategic Planning Subcommittee on Education Programs

OTHER UNIVERSITY OF CALIFORNIA CAMPUSES
1980-1992 Diving Control Board, University of California, Berkeley
1989-1991 Advisory Panel, "AIDS Utilization and Costs in Los Angeles and San Francisco" Project, UCSF Institute for Health Policy Studies
1993-1993 Prevention in Health Care Reform Advisory Group, School of Public Health, University of California, Berkeley

UNIVERSITY OF SOUTHERN CALIFORNIA (USC)
1981-1985 Medical Advisory Board, Western Regional Undersea Laboratory, USC/National Oceanic and Atmospheric Administration, Catalina Island, California
1988-1989 Advisory Committee, Institute for Health Promotion and Disease Prevention Research
1987- Advisory Board, Health Services Administration Program, School of Public Administration, Sacramento Public Affairs Center
1994- Adjunct Professor of Public Administration and Health Policy, School of Public Administration

SELECTED COMMITTEES, BOARDS, TASK FORCES AND OTHER POSITIONS
Boards of Directors and Governing Boards
1994- Health Systems International, Woodland Hills, California
1993- Eagle Lake Children's Charities and Camp Ronald McDonald at Eagle Lake, Sacramento, California.
1992- The California Wellness Foundation. Woodland Hills, California.
1992- Center for AIDS Research, Education and Services (CARES). Sacramento, California.
1991- The Mathews Foundation for Prostate Cancer Research. Sacramento, California.
1988-1992 National Association of Underwater Instructors (NAUI). Montclair, California.
1988-1992 NAUI Diving Association. Montclair, California.
1988-1989 San Francisco Bay Area Youth Excellence Initiative. San Francisco, California.
1988-1990 American Trauma Society. Chicago, Illinois.
1987-1990 California Division, American Trauma Society. San Francisco, California.
1986-1990 Association of State and Territorial Health Officials (ASTHO). McLean, Virginia.
1986-1990 California YMCA Model Legislature and Court Program. San Mateo, California.

1984-1985 National Society of YMCA Youth Governors. Rustburg, Virginia.
1983-1989 Wilderness Medical Society. Indianapolis, Indiana.
1983-1984 Undersea Medical Society. Bethesda, Maryland.
1978-1980 Hawaii Undersea Medical Association. Honolulu, Hawaii.

Nongovernmental Advisory Boards and Panels

1994- Committee on Health Services Research Training and Workforce Issues, Institute of Medicine/National Academy of Sciences. Washington, D.C.
1994- Advisory Council, Academy for International Health Studies, Inc. Davis, California. 1994- Advisory Board, Adventure Medicine. Point Reyes Station, California.
1993- National Health and Safety Committee, Boy Scouts of America. Irving, Texas.
1993- Expert Advisory Panel, The National Project to Develop a Strategic Plan for Changing the American Diet; Association of State and Territorial Health Officials and Affiliates (ASTPHND, ASTDCDP, ASTDPHE)
1993- Wilderness Risk Managers Committee; c/o National Outdoor Leadership School, Lander, Wyoming.
1992- National Advisory Panel for the WELL CITY USA Initiative, Wellness Councils of America. Omaha, Nebraska.
1992- Research Committee, American Cancer Society, California Division. Oakland, California.
1991- Preventative Sports Medicine Institute. Ann Arbor, Michigan.
1991- Corporate Member, Blue Shield of California. San Francisco, California. 1991- Infection Control Council, L & F Products, Inc. Montvale, New Jersey.
1990- Committee on Diving Instructional Standards and Safety, Z375. American National Standards Institute.
1986-1987 Medical Advisory Committee, American Academy of Underwater Sciences. Costa Mesa, California.
1986-1991 Advisory Committee for the AIDS Education for Emergency Workers Project, American Red Cross and California Firefighter Foundation. Sacramento, California.
1983-1984 Health and Safety Technical Advisory Committee, Federated Fire Fighters of California. Sacramento, California.

Federal Government Committees. Boards and Panels

1992- Interagency Committee on Smoking and Health, Office of the Surgeon General and Centers for Disease Control and Prevention, U.S. Public Health Service
1990-1991 Injury Control Panel on Acute Care Treatment, Centers for Disease Control, Center for Environmental Health and Injury Control
1988-1991 Management Committee, Santa Monica Bay Restoration Project (a National Estuary Program project); sponsored by the Environmental Protection Agency and other agencies
1988-1988 Consultant, Management Oversight Committee for Policy on Management of Public Health Advisory Field Staff, Centers for Disease Control
1984-1985 National Disaster Medical System Advisory Group, U.S. Public Health Service
1984-1985 U.S. Planning Group for Earthquake Preparedness of the U.S. Working Group on Geological Phenomena of the U.S./Mexico Consultative Committee on Natural Disasters, Federal Emergency Management Agency

California State Government Commissions. Committees. Boards and Panels

Governor's, Legislative and Interagency
1990-1994 Tobacco Education Oversight Committee
1990-1991 Chair Pro-Tem, Southwest Low Level Radioactive Waste Compact Commission
1989-1994 Chairman, California Radiation Emergency Screening Team
1991-1991 Governor's Drought Action Team
1989-1991 Governor's Task Force for the Africanized Honey Bee
1989-1990 Chair, Interagency Task Force for the Oversight of Department of Energy Facilities in California
1989-1990 Chairman, Hazardous Waste Appeal Board
1987-1990 AIDS Vaccine Injury Compensation Policy Review Task Force
1987-1991 Chemical Emergency Planning and Response Commission
1987-1988 California State Task Force on California-Mexico Relations
1986-1991 Chairman, AIDS Vaccine Research and Development Advisory Committee
1986-1991 Governor's Cabinet Working Group on The Safe Drinking Water and Toxic Enforcement Act of 1986 [Proposition 65]
1986-1991 Safe Drinking Water Finance Committee
1986-1990 Governor's Interagency Task Force on Biotechnology

1985-1986 Governor's Task Force on Toxics, Waste and Technology
1984-1991 Governor's Emergency Operations Executive Council
1985-1991 Scientific Advisory Committee on Ocean Disposal of Radioactive Waste
1984-1989 Governor's Intergovernmental Advisory Council on Alcohol, Drugs and Traffic Safety
1983-1991 Intergovernmental Committee on Emergency Medical Services (Chairman 1983-84, Member 1984-91)
1983-1984 Secretary, Commission on Emergency Medical Services Department of Health Services
1990-1991 Chair, Lyme Disease Steering Committee
1989-1991 Chair, Black Infant Health Leadership Committee
1989-1991 Chair, Animal Bite Advisory Committee
1989-1990 Chair, Tobacco Use Prevention Interim Advisory Committee for Proposition 99
1988-1991 Co-Chair, California AIDS Leadership Committee
1988-1991 Chair, MacFarland Cancer Cluster Scientific Advisory Committee
1988-1990 Chair, Safety Net Provider Task Force
1987-1989 Chair, Long Term Care Task Force
1985-1987 Chair, Interdepartmental Advisory Committee on AIDS Emergency Medical Services Authority
1984-1985 EMS Systems General Guidelines Task Force
1983-1984 EMT-Paramedicic Task Force
1983-1984 EMT-II Task Force
1984-1984 Chair, EMS Dispatcher Advisory Committee
1984-1984 Chair, Poison Center Standards Advisory Committee
1984-1984 California Trauma Care Advisory Committee

Miscellaneous State Agencies
1994- Medical Expert Reviewer, Medical Board of California
1992-1994 Human Health Subcommittee, Comparative Risks Project, California Environmental Protection Agency
1988-1990 Transuranic Waste Shipment Interagency Task Force, California Energy Commission
1989-1990 California Safety Belt Task Force, Department of Highway Patrol
1987-1988 Nuclear Emergency Response Task Force, State Senate
1986-1987 Child Care Blue Ribbon Advisory Committee, Commission on California State

Government Organization and Economy
1986-1990 Interagency Coordinating Committee on Seismic Safety, Seismic Safety Committee
1985-1986 Chair, Minority Health Coordinating Council, Health and Welfare Agency
1985-1985 Selenium Studies Task Force, Resources Agency
1984-1986 Sexual Assault Medical Protocol Committee, Office of Criminal Justice Planning
1984-1985 Pesticide Issues Committee, Department of Food and Agriculture

Professional Societies and Other
Association of State and Territorial Health Officers
- Member (1985-90)
- Secretary-Treasurer (1989-90)
- AIDS Task Force (1986-90)
- Executive Committee (1986-90)
- Region IX and X Representative (1986-89)
- Chairman, Food and Drug Administration Liaison Committee (1986-88)
- Resolutions Committee (1986-89)
- Liaison to the State Public Health Vector Control Conference (1987-88)

American Trauma Society
- Member (1987-90)
- Board of Directors (1988-1990)
- Board of Directors, California Division (1987-89)
- Prevention Committee (1988-90)
- State Activity/Development Committee (1988-90)

National Association of State Emergency Medical Services Directors
- Member (1983-84)
- Federal Lands Committee (1983-84)
- Information Coordinator, Region IX (1984)

California Medical Association
Member (1973-76, 1980-84, 1994-)
Committee on Disaster Medical Care - Student Member (1973-74), Consultant (1983-84)
Committee on Professional Liability-Student Member (1974-75)
Committee on Environmental Health-Student Member (1975-76)
Emergency Medical Care Committee - Consultant (1982-83, 1984-85), Member (1983-84)
Cal-EDNA MICN Standards Committee (1983)
Commission on State Legislation-Consultant (1985-88)
Advisory Panel on Preventive Medicine and Public Health (1991-)
Marin County Chapter (1980-84)
Placer-Nevada County Chapter (1994-)

American College of Emergency Physicians
Member (1978-)
Hawaii Chapter (1978-80)
California Chapter (1980-)
Instructor, Disaster Planning and Management for Emergency Physicians course (certified in 1983)
Emergency Medical Services Committee (1983-84)
Speakers Bureau (1984-85)
Task Force on AIDS and the Emergency Department (1987-91)

Undersea and Hyperbaric Medical Society
Member (1976-)
President, North Pacific Chapter (1981-82)
Chairman, Constitution and Bylaws Committee (1981-82)
North American Affairs Committee (1981-83)
Secretary (1983-84)
Executive Committee (1983-84)
Nominations Committee (1983-84)
Chairman, Nitrogen Narcosis Workshop (1983)
Education Committee (1984-86)
Ad Hoc Undersea Medicine Certification Committee (1989-90)

Wilderness Medical Society
Founding and life member
President-elect (1983-85)
President (1985-87)
Secretary-Treasurer (1987-89)
Board of Directors (1983-89)
Chairman and Program Organizer, 2nd Annual Scientific Meeting (1985-86)
Chairman and Program Organizer, 3rd Annual Scientific Meeting (1986-87)
Editorial Board, *Journal of Wilderness Medicine* (1989-)
Finance Committee (1989-91)
Book review editor, *Wilderness Medicine Letter* and *Journal of Wilderness Medicine* (1989-94)
Founders Society
Chairman, Liaison and External Affairs Committee (1991-94)
Program Committee, 8th Annual Scientific Meeting (1991-92)
Nominations and Awards Committee (1988-)
Contributor, Wilderness Medicine Teaching Slide Set Project
Chairman, Program Committee, 1992 Marine and Tropical Medicine Program (1992-93)
Representative to the Wilderness Risk Managers Committee meeting (1993)
Program Committee, Second World Congress on Wilderness Medicine (1993-)

BIBLIOGRAPHY

JOURNAL AND SERIAL ARTICLES

1. Kizer KW: Epidemiological and clinical aspects of animal bite injuries. *Journal of the American College of Emergency Physicians* 1979; 8:134-141.
2. Kizer KW: Dysbarism in paradise. *Hawaii Medical Journal* 1980; 39: 109-116.
3. Kizer KW:-Medical hazards of the water skiing douche. *Annals of Emergency Medicine* 1980;9: 268-269.
4. Kizer KW: Ventricular dysrhythmia associated with serious decompression sickness. *Annals of Emergency Medicine* 1980; 9: 580-584.

5. Kizer KW: Women and diving. *The Physician and Sportsmedicine* 1981; 9 (#2): 84-92.
6. Kizer KW and Milroy WC: Dysbarism associated with alcohol abuse. *Hawaii Medical Journal* 1981; 40:12-15.
7. Kizer KW and Ogle LK: Occult clostridial myonecrosis - a case report and review. *Annals of Emergency Medicine* 1981; 10: 307-311.
8. Kizer KW: Corticosteroids in the treatment of serious decompression sickness. *Annals-Emergency Medicine* 1981; 10: 485489.
9. Kizer KW: The role of computed tomography in the management of dysbaric diving accidents. *Radiology* 1981; 140: 705-707.
10. Kizer KW: Delayed treatment of dysbarism - a retrospective review of 50 cases. *Journal of the American Medical Association* 1982; 247: 2555-2558.
11. Kizer KW and Piel M: Arterial blood gas changes associated with bluebottle envenomation. *Hawaii Medical Journal* 1982; 41:193-194.
12. Kizer KW and Goodman PC: Radiographic manifestations of venous air embolism. *Radiology* 1982; 144: 35-39. Adapted, When air invades a vein. *Emergency Medicine* 1983; 15 (#8): 51-55.
13. Kizer KW: Management of dysbaric diving casualties. *Emergency Medicine Clinics of North America* 1983; 1: 659~70.
14. Kizer KW: Resuscitation of submersion casualties. *Emergency Medicine Clinics of North America* 1983; 1: 643652.
15. Kizer KW and Naccari PF: Recognizing and managing common toxic inhalations. *ER Reports* 1983; 4: 51-58.
16. Kizer KW, Garb LG and Hine CH: Health effects of silicon tetrachloride - report of an urban accident. *Journal of Occupational Medicine* 1984; 26: 33-36.
17. Kizer KW: Disorders of the deep. *Emergency Medicine* 1984; 16 (#12): 18-58.
18. Kizer KW and Hawkins C: Immunizations: avoiding pitfalls with old and new vaccines. *Family Medicine Reports* 1984; 2:141-156.
19. Kizer KW, Callaham M and Sinkinson CA: A new look at managing mammalian bites. *Emergency Medicine Reports* 1984; 5: 53-58.
20. Kram J and Kizer KW: Submersion injuries. *Emergency Medicine Clinics of North America* 1984; 2: 545-552.
21. Kizer KW: Diving medicine. *Emergency Medicine Clinics of North America* 1984; 2:513-530.
22. Kizer KW: Toxic inhalations. *Emergency Medicine Clinics of North America* 1984; 2:649666.
23. Kizer KW: Marine envenomations. *Journal of Toxicology/Clinical Toxicology* 1983-~4~ 21:527-555.
24. Kizer KW, Auerbach PS and Dwyer BA: Marine envenomations: not just a problem of the tropics. *Emergency Medicine Reports* 1985; 6:129-135.
25. Kizer KW, McKinney HE and Auerbach PS: Scorpaenidae envenomation: a five year poison control center experience. *Journal of the American Medical Association* 1985; 253: 807-810. Adapted, A simple solution to Scorpaenidae stings. *Emergency Medicine* 1985; 17 (#16): 6369.
26. Dales LG and Kizer KW: Measles transmission in medical facilities. *Western Journal of Medicine* 1985; 142:415-416.
27. Kizer KW: Shark attack. *Emergency Medical Services* 1986; 15: 31-34.
28. Auerbach PS, Osterloh J, Braun O, Hu P, Geehr EC, Kizer KW and McKinney H: Efficacy of gastric emptying: gastric lavage versus emesis induced with ipecac. *Annals of Emergency Medicine* 1986; 15: 692698.
29. Kizer KW: Dysbaric cerebral air embolism in Hawaii. *Annals of Emergency Medicine* 1987;16: 535-541.
30. Isman R and Kizer KW: Preventive dentistry update: dental sealants. *Western Journal of Medicine* 1987; 146: 631632.
31. Kizer KW: Medical problems in whitewater sports. *Clinics of Sports Medicine* 1987; 6:663668.
32. Auerbach PS, Yajko DM, Nassos PS, Kizer KW, McCosker JE, Geehr EC and Hadley K:Bacteriology of the marine environment: implications for clinical therapy. *Annals of Emergency Medicine* 1987; 16: 643649.
33. Kizer KW: Medical aspects of whitewater kayaking. *The Physician and Sportsmedicine* 1987;15 (#7): 128-137.
34. Grether JK, Harris JA, Neutra R and Kizer KW: Exposure to aerial malathion application and the occurrence of congenital anomalies and low birth weight. *American Journal of Public Health* 1987; 77:1009-1010.
35. Kizer KW: Whitewater medicine. *Emergency Medicine* 1987; 19 (#14): 90-106.
36. Auerbach PS, Yajko DM, Nassos PS, Kizer KW, Morris JA and Hadley WK: Bacteriology of the freshwater environment: implications for clinical therapy. *Annals of Emergency Medicine* 1987; 16:1016-1022.

37. Kizer KW and Golden JA: Lipoid pneumonitis in a commercial abalone diver. *Undersea Biomedical Reports* 1987; 14: 545-552.
38. Kizer KW: Challenges to balancing access, quality and cost containment in publicly supported health care programs. *Whittier Law Review* 1987; 9:179-184.
39. Dales L, Kizer KW and Elliot GV: Joint California Department of Health Services-California Medical Association campaign to eliminate congenital rubella syndrome. *Western Journal of Medicine.* 1988; 148: 355-357.
40. Kizer KW, Warriner TE and Book SA: Sound science in the implementation of public policy: a case report on California's Proposition 65. *Journal of the American Medical Association* 1988;260: 951-955.
41. Kizer KW: California's approach to AIDS. *AIDS & Public Policy Journal* 1988; 3 (#4): 1-10.
42. Perkins CI, Kizer KW, Hughes MJ, Holland PV and Lloyd JC: Anti-HIV seroprevalence in California blood and plasma donors. *Western Journal of Medicine* 1988; 149: 620622.
43. Kizer KW: California's response to the AIDS epidemic. *Whittier Law Review* 1989; 10:101-110.
44. Kizer KW, Conant MA, Francis DP and Fraziear T: HIV disease prevention and treatment: a model for local planning. *Western Journal of Medicine* 1988; 149: 481485.
45. Doebbert G, Riedmiller KR and Kizer KW: Occupational mortality of California women, *Western Journal of Medicine* 1988; 149: 734-740.
46. Kizer KW: *Pasteurella multocida* infection from a cougar bite: a case report and review of cougar attacks. *Western Journal of Medicine* 1989; 150: 87-90.
47. Saunders LD, Green M, Doebbert G, Pearson MA and Kizer KW: Mortality from unintentional injuries in California 1985. *Western Journal of Medicine* 1989; 150: 478483.
48. Spain C, Eastman E and Kizer KW: Model standards impact on local health department performance in California. *American Journal of Public Health* 1989; 79: 969-974.
49. Kizer KW, Felton JA, Jodar VA, Yamamoto HE and Montes JM: Penicillinase- producing *Neiserria gonorrhoeae* in California: Report of a major outbreak and control recommendations. *Western Journal of Medicine* 1989; 151: 292-295.
50. Alexeff GV, Lipsett MJ and Kizer KW: Problems associated with the use of immediately dangerous to life and health (IDLH) values for estimating the hazard of accidental chemical releases. *Journal of the American Industrial Hygiene Association* 1989; 50: 598605.
51. Goldman LR, Hayward DG, Flattery J, Hamly ME, Patterson DG, Needham L, Siegel D, Chang R, Stephens R and Kizer KW: Serum, adipose and autopsy PCDD and PCDF levels in people eating dioxin contaminated beef and chicken eggs. *Chemosphere* 1989; ~9: 841-848.
52. Francis DP, Anderson RE, Gorman ME, Fenstersheib M, Padian NS, Kizer KW and Conant MA: Targeting AIDS prevention and treatment towards HIV-1 infected persons: the concept of early intervention. *Journal of the American Medical Association* 1989; 262: 2572-2576.
53. Kizer KW, Fan AM, Bankowska J, Jackson RI and Lyman DO: Vitamin A: A pregnancy hazard alert. *Western Journal of Medicine* 1990; 152: 78-81.
54. Appel BA, Guirguis G, Kim I, Garb in O, Fracchia M, Flessel P, Kizer KW, Book SA and Warriner TE: Benzene, benzo(a)pyrene and lead in tobacco smoke. *American Journal of Public Health* 1990; 80: 560-564.
55. Fan AM and Kizer KW: Selenium: nutritional, toxicological and clinical aspects. *Western Journal of Medicine* 1990; 153: 160-167.
56. Goldman LR, Smith DF, Neutra RR, Saunders LD, Pond EM, Stratton J, Waller K, RI Jackson and Kizer KW: Pesticide food poisoning from contaminated watermelons, California, 1985: Acute illness and pregnancy follow-up. *Archives of Environmental Health* 1990; 45:229-236.
57. Bal DG, Kizer KW, Felten PG, Mozar HN and Niemeyer D: Reducing tobacco consumption in California: Development of a statewide anti-tobacco use campaign. *Journal of the American Medical Association* 1990; 264:1570-1574.
58. Singleton J, Perkins CI, Trachtenberg AI, Hughes MJ, Kizer KW and Ascher M: HIV antibody seroprevalence among prisoners entering the California correctional system. *The Western Journal of Medicine* 1990; 153: 394-399.
59. Kizer KW, Truax S, Ramirez A and Fraziear TF: California's alternative test site program: the first four years. *AIDS & Public Policy Journal* 1990; 5: 24-28.
60. Maizlish N, Rudolph L, Sutton P, Jones JR and Kizer KW: Elevated blood lead in California adults, 1987: results of a statewide surveillance program based on laboratory reports. *American Journal of Public Health* 1990; 80: 931-934.
61. Kizer KW: When a stingray strikes; treating common marine envenomations. *The Physician and Sportsmedicine* 1990; 18 (#8): 93-109.
62. Cunningham GC and Kizer KW: Maternal serum alpha fetoprotein screening activities of state health agencies: a survey. *American Journal of Human Genetics* 1990; 47: 899-903.

63. Kizer KW and Trent RB: Safety belts and public health: the role of medical practitioners. *Western Journal of Medicine* 1991; 154: 303-306.
64. Price DW, Kizer KW and Hansgen KH: California's paralytic shellfish poisoning prevention program, 1927-1989. *Journal of Shellfish Research* 1991; 10:119-145.
65. Kizer KW: Wilderness emergencies: be prepared. *Emergency Medicine* 1991; 23 (#8): 88-102.
66. Kizer KW: Guidelines for community-based screening for chronic health conditions. *American Journal of Preventive Medicine* 1991; 7:117-120.
67. Kizer KW, Folkers LF, Felten PG and Neimeyer D: Quality assessment in worksite health promotion. *American Journal of Preventive Medicine* 1992; 8; 123-127.
68. Kizer KW: Aquatic infections: from the benign to the life-threatening. *Emergency Medicine* 1991; 23 (#13): 77-90.
69. Kizer KW: Meeting the challenge of scuba diving emergencies: recognition, resuscitation and recompression. *Emergency Medicine Reports* 1991; 12: 151-160.
70. Singleton JA, Otten MW, Doebbert G and Kizer KW: Premature mortality related to human immunodeficiency virus infection in California, 1981-1993. *Journal of Acquired Immune Deficiency Syndromes* 1992; 5: 688~93.
71. Rhee KJ, Albertson TE, Kizer KW, Hughes MJ, Ascher MS and the California HIV-1 Emergency Department Seroprevalence Study Group: The HIV-1 seroprevalence rate of injured patients admitted through California emergency departments. *Annals of Emergency Medicine* 1991; 20: 969-972.
72. Kizer KW: Treating insect stings. *The Physician and Sportsmedicine* 1991; 19 (#8): 33-36.
73. Andrews R, Keyes M, Fanning T and Kizer KW: Lifetime Medicaid service utilization and expenditures for AIDS in New York and California. *Journal of Acquired Immune Deficiency Syndromes* 1991; 4:1046-1058.
74. Kizer KW: Wilderness medicine and the backcountry medical kit. *Resident and Staff Physician* 1991; 37(#11): 79-92.
75. Capell FJ, Vugia DJ, Moraunt VL, Marelich WD, Ascher MS, Trachtenberg AI, Cunningham GC and Kizer KW: Distribution of human immunodeficiency virus type-I infection in childbearing women in California. *American Journal of Public Health* 1992; 82: 254-256.
76. Beaumont JJ, Singleton JA, Doebbert G, Reidmiller KR, Brackbill RM and Kizer KW: Adjustment for smoking, alcohol consumption, and socioeconomic status in the California Occupational Mortality Study, with special reference to agricultural occupations. *American Journal of Industrial Medicine* 1992; 21: 491-506.
77. Rhee KJ, Albertson TE, Kizer KW, Burns MJ, Hughes MJ, Ascher MS and the California HIV-1 Emergency Department Seroprevalence Study Group: A comparison of HIV-1, HBV and HTLV I-II seroprevalence rates of injured patients admitted through California emergency departments. *Annals of Emergency Medicine* 1992; 21: 397401.
78. King EK, Werner SB and Kizer KW: The epidemiology of *Aerornonas* infections in California. *Clinical Infectious Diseases* 1992:15: 499452.
79. Smith MW, Kreutzer R, Goldman LR and Kizer KW: Access to medical care in a rural California agricultural community. *Medical Care.* Submitted for publication.
80. Sutocky JW, Shultz JM and Kizer KW: Alcohol-related mortality in California, 1980 to 1989. *American Journal of Public Health* 1993; 83: 817-823.
81. Salmon AG, Kizer KW, Zeise L, and Smith MT: Potential cancer hazard from pediatric use of chloral hydrate. *Journal of Toxicology - Clinical Toxicology.* Submitted for publication.
82. Wilson MJ, Marelich WD, Lemp GF, Ascher M, Kerndt P, Kizer KW and the California Family of Surveys and Sentinel Surveillance Consortia: HIV-1 antibody seroprevalence among women attending sexually transmitted disease clinics in California, 1989. *Western Journal of Medicine* 1993; 158: 40-43.
83. Hay JW and Kizer KW: Medi-Cal expenditures for persons with AIDS. *AIDS & Public Policy Journal* 1993; 8: 91-102.
84. Kizer KW: Undersea emergencies: treating barotrauma and the bends. *The Physician and Sportsmedicine* 1992; 20: 3948.
85. Lewis FR, Gennarelli TA, Pollack DA, Johnson D, Demling RH, Ehrlich F, Eichelberger MR, Fleming AW, Ferguson JH, Kizer KW, Narayan RK, Rozycki G, Shires GT, Trafton PG, Trunkey DD, Weigelt J and Burton N: Setting the national agenda for injury control in the 1990s: Executive summary of the position paper on acute care treatment. *The Journal of Trauma* 1992; 32:130-132.
86. Dales LG, Kizer KW, Rutherford GW, Pertowski CA, Waterman SH, and Woodford G:Measles epidemic from failure to immunize. *Western Journal of Medicine* 1993; 159: 455464.
87. Goldman LR, Haan M, Sutton P, Mann J, McLaughlin R, Zahler L, Broadwin R, Guirguis G, Flessel P, Athanasoulis M, Chin MY, Schlag R and Kizer KW: Childhood lead exposure in

three high-risk communities in California: environmental and demographic correlates. *American Journal of Epidemiology*. Submitted for publication.

88. Sutton P, Athanasoulis M, Flessel P, Guirguis G, Haan M, Schlag R, Kizer KW and Goldman L: Household lead exposures in the environment of children in three high-risk communities in California. *American Journal of Epidemiology*. Submitted for publication.
89. Chernoff GF, Book SA, Milanes C, Kizer KW and Zeise L: Update on an experiment in science and public policy: six years experience with California's Proposition 65. *Journal of the American Medical Association*. Submitted for publication.
90. Foerster SB, Kizer KW, Bal DG, Disogra L, Krieg DF and Bunch KL: California's "5 A Day For Better Health" campaign: an innovative population-based effort to effect large scale dietary change. *Amercian Journal of Preventive Medicine*. In press.
91. Phillips KA, Foerster SB, Kizer KW, Clancy K and Bal DG: Implications for coalitions to promote healthy policies from an evaluation of California's Nutrition and Cancer Prevention Program. *Health Education Quarterly*. Submitted for publication.
92. Kizer KW: Public health, agribusiness can forge new partnerships. *Californic Agriculture*. 1994; 48: 3640.
93. Langlois GW, Kizer KW, Hansgen KH, Howel R and Loscutoff SM: A note on domoic acid in California coastal molluscs and crabs. *Journal of Shellfish Research* 1993; 12: 467-468.
94. Kizer KW, MacQuarrie MB, Kuhn BH and Scannell PD: Deep snow immersion deaths in snowboarding. *The Physician and Sportsmedicine* 1994; In press.
95. Goldman LR, Chin MY, Haan M and Kizer KW: Lead screening in a high-risk community - issues of access and missed opportunities. *American Journal of Public Health*. Submitted for publication.
96. Kizer KW, Vassar MJ, Harry RL and Layton KD: Hospitalization charges, costs and income for firearm injuries at a university trauma center, 1990-1992. *New England Journal of Medicine*. Submitted for publication.

BOOKS

1. Kizer KW (ed): "Environmental Emergencies," *Emergency Medicine Clinics of North America*, Volume 2 (#3). W.B. Saunders Company, Philadelphia, 1984.
2. Hamilton RH and Kizer KW (eds): *Nitrogen Narcosis - Proceedings of the Twenty-Ninth Undersea Medical Society Workshop*. Undersea Medical Society, Rockville (Maryland), 1985.
3. Kizer KW: *Attacks by Wild Animals of North America*. Merrillville, Indiana. ICS Books, Inc. In preparation.

BOOK CHAPTERS

1. Kizer KW: Spontaneous pneumothorax and diving. In: Shilling CW, Carlston CB and Mathias RA (eds), *The Physician's Guide to Diving Medicine*, New York, Plenum Press, 1984. pp. 441-444. Also printed in the *Journal of the National Association for Cave Diving* 1985; 2: 21-29; and *Pressure* 1982; 11:12-13.
2. Kizer KW: Dysbaric diving accidents. In: Edlich RF and Spyker DA (eds), *Current Emergency Therapy 84*, Appleton-Century-Crofts, East Norwalk, Connecticut, 1984. pp 219-226. Revised for *Current Emergency Therapy 85*, Aspen Systems Corporation, Rockville, Maryland. 1985. pp 271-277.
3. Kizer KW: High altitude illness. In: Edlich RF and Spyker DA (eds), *Current Emergency Therapy 84*, Appleton-Century-Crofts, East Norwalk, Connecticut, 1984. pp 231-234. Revised for *Current Emergency Therapy 85*, Aspen Systems Corporation, Rockville, Maryland. 1985. pp 277-281.
4. Kizer KW: Dysbaric diving casualties. In: Tintinalli JE, Rothstein RI and Krome RL (eds), *Emergency Medicine: A Comprehensive Study Guide*. McGraw-Hill Book Company, New York, 1985. pp 367-375. Revised for the second edition, 1988. pp 781-788. Revised for the third edition and incorporated into chapter on Dysbarism, 1991. pp 678687. Revision for fourth edition, 1994. In preparation.
5. Kizer KW: Blast injury. In: Tintinalli JE, Rothstein RI and Krome RL (eds), *Emergency Medicine:A Comprehensive Study Guide*, McGraw-Hill Book Company, New York, 1985. pp 376-378. Revised for the second edition, 1988. pp 788-791. Revised for the third edition and incorporated into chapter on Dysbarism, 1991. pp 678687.
6. Kizer KW: Mountain sickness and other acute high altitude illnesses. In: Tintinalli JE, Rothstein RI and Krome RL (eds), *Emergency Medicine: A Comprehensive Study Guide*, McGraw-Hill Book Company, New York, 1985. pp 379-382. Revised as, Auerbach PS and Kizer KW, High-altitude illnesses, for the second edition, 4988. pp 776-780.
7. Kizer KW: Compressed-air diving accidents. In: Nelson RN, Rund DA and Keller MD (eds), *Environmental Emergencies*, W.B. Saunders Company, Philadelphia, 1985. pp 115-138.

8. Kizer KW: Clinical applications of hyperbaric oxygen. In: Nelson RN, Rund DA and Keller MD (eds), *Environmental Emergencies*, W.B. Saunders Company, Philadelphia, 1985. pp 326-335.
9. Kizer KW: Introduction (Chapter I), Nitrogen narcosis and diver casualty management (Chapter X), and General discussion and conclusions (Chapter XI). In: Hamilton RH and Kizer KW (eds), *Nitrogen Narcosis*, Undersea Medical Society, Rockville (Maryland), 1985.
10. Kizer KW: Scuba diving accidents. In: Callaham M (ed), *Current Therapy in Emergency Medicine*, B.C. Decker, Inc., Philadelphia, 1987. pp 902-905. Revised for second edition entitled *Current Practice of Emergency Medicine*, 1991. pp 1085- 1089.
11. Kizer KW: Medical aspects of scuba diving. In: Noble J (ed), *Textbook of General Internal Medicine and Primary Care*, Little, Brown & Company, Boston, 1987. pp 365-376.
12. Davis JC and Kizer KW: Diving medicine. In: Auerbach PS and Geehr EC (eds), *Management of Wilderness and Environmental Emergencies*, 2nd ed, C.V. Mosby Company, St. Louis, 1989. pp 879-905.
13. Kizer KW: Health care expenditures for AIDS under the Medi-Cal program: 1983-86. In: Fox DM and Thomas EH (eds), *Financing Care for Persons with AIDS: The First Studies. 1985-88.* University Publishing Group, Frederick, Maryland, 1989. pp 65-77.
14. Kizer KW: Marine envenomations. In: Harwood-Nuss AL, Linden CH, Luten RC, Sternbach G and Wolfson AB (eds), *The Clinical Practice of Emergency Medicine*. J.B. Lippincott Company, Philadelphia. 1991. pp 609612. Revised for the second edition, 1994. In press.
15. Young M and Kizer KW: Wilderness emergencies. In: Grossman M and Dieckmann RA (eds), *Pediatric Emergency Medicine*. J.B. Lippincott Company, Philadelphia, 1990. pp 454460.
16. Kizer KW: Compressed air diving emergencies. In: Callaham M, Schumaker H and Barton C (eds), *Decision Making in Emergency Medicine*. B.C. Decker, Inc., Ontario, Canada, 1990. pp 384-385.
17. Kizer KW: Improving health care quality requires organizational commitment arising from internal motives and assured by appropriate external oversight. In: *Cornerstones of Health Care in the Nineties: Forging a Framework of Excellence*. Joint Commission on Accreditation of Health Care Organizations and The Prudential, Chicago, 1990. pp 25-29.
18. Kizer KW: Animal bites. In: Gorbach SL, Bartlett JG and Blacklow NR (eds), *Infectious Diseases*. W.B. Saunders Company, Philadelphia, 1992. pp 1277-1280.
19. Kizer KW: The scuba diving traveler. In: *Travel Medicine Advisor*. American Health Consultants, Atlanta, 1992; pp 24.1-24.17.
20. Kizer KW: Scuba diving and dysbarism. In: Auerbach PS (ed), *Management of Wilderness and Environmental Emergencies*, 3rd ed, C.V. Mosby Company, St. Louis, 1994. In press.
21. Kizer KW: Compressed air diving and hyperbaric environments. In: Harbor P, Schenker M, Balmes J (eds), *Occupational and Environmental Respiratory Disease*. Mosby, St. Louis. 1994. In press.

LETTERS TO THE EDITOR. EDITORIALS, EPITOMES AND SIMILAR MATERIALS

1. Kizer KW: Animal bites - author's reply (Pasteurella multocida infections complicating animal bites). *Journal of the American College of Emergency Physicians* 1979; 8: 546.
2. Kizer KW and Larsen RT: Delayed treatment of type I decompression sickness. *Pressure* 1980;9 (#1): 1-2.
3. Kizer KW: Mannitol in dysbarism. *Western Journal of Medicine* 1980; 132: 86.
4. Kizer KW and Pegg J: Managing scuba emergencies. *Hospital Physician* 1980 (September). pp 14,30.
5. Kizer KW: Possible interaction of TCA and marijuana. *Annals of Emergency Medicine* 1980;9: 440.
6. Kizer KW: Gas gangrene and hyperbaric oxygen therapy. *American Journal of Roentgenology* 1981; 136: 635-636.
7. Kizer KW: Aquatic medicine in Hawaii. *Hawaii Medical Journal* 1981; 41: 325.
8. Kizer KW: Gastrointestinal barotrauma. *Western Journal of Medicine* 1981; 133: 449450.
9. Kizer KW: Initial management of the dysbaric diving casualty. *The Physician and Sportsmedicine* 1981; 9 (#10): 53.
10. Kizer KW: Aquatic rescue and in-water CPR. *Annals of Emergency Medicine* 1982; 11:166-167.
11. Kizer KW, Kram J, Dobbs LG and Herskowicz F: Carbon monoxide poisoning and HBO. *Western Journal of Medicine* 1982; 136: 163-164.
12. Kizer KW: Diabetes and diving. *Pressure* 1983; 12 (#1): 2-3.
13. Kizer KW: Hemorrhagic hereditary telangiectasia and diving. *Pressure* 1983; 12 (#4): 34.
14. Kizer KW: Hyperbaric emergencies (Epitomes in Emergency Medicine). *Western Journal of Medicine* 1983; 138: 87-88.

15. Kizer KW: Radiography of cervical spine trauma (Epitomes in Emergency Medicine). *Western Journal of Medicine* 1983; 138: 90.
16. Kizer KW: Hyperbaric oxygen and cyanide poisoning. *American Journal of Emergency Medicine* 1984; 2:113.
17. Kizer KW: Decompression sickness or Portuguese man-of-war envenomation? *Wilderness Medicine* 1984; 1 (#3): 7-8.
18. Kizer KW: Intracranial hemorrhage associated with overdose of decongestant containing phenylpropanolamine. *American Journal of Emergency Medicine* 1984; 2:180-181.
19. Kizer KW and Hamilton RW: Nitrogen narcosis. *Pressure* 1984 (#7); 13: 3-5. Adapted and reprinted in *South Pacific Underwater Medicine Society Journal* 1985; 15:14-15; *Diver* Sep 1984, p IQ and *NAUI News* Dec 1984, pp 15-18.
20. Kizer KW: Domestic violence: an EMS-targeted clinical condition in California. *Annals of Emergency Medicine* 1984; 13:1082.
21. Kizer KW and Morrison FR: Reporting requirements for Reye's Syndrome and AIDS in California. *Western Journal of Medicine* 1985; 142: 558.
22. Kizer KW: Health problems of agricultural and forestry workers. *Western Journal of Medicine* 1985; 143: 693-694.
23. Kizer KW: Wilderness medicine: future directions. *Wilderness Medicine* 1985; 2 (#3): 5-7.
24. Kizer KW: Hospital-based helicopter ambulance programs. *Emergency Department News.* December 1985. p 2.
25. Kizer KW and Martland L: Is capitation good for pharmacists? *Drug Topics* January 20, 1986. p 12.
26. Kizer KW: Monoplace chamber treatment of dysbaric diving diseases. *Journal of Hyperbaric Medicine* 1986; 1:137-138.
27. Stratton JW, Jackson RJ, Goldman LR, Kelter A, Neutra RR and Kizer KW: Aldicarb food poisoning from contaminated melons - California. *Morbidity and Mortality Weekly Report* 1986; 35: 254-258.
28. Ames RG, Knaak JB, Jackson R and Kizer KW: Outbreak of severe dermatitis among orange pickers - California. *Morbidity and Mortality Weekly Report* 1986; 35: 465467.
29. Kizer KW: Wilderness medicine. *The Bulletin of Polk County Medical Association* 1987; 28:6,8.
30. Kizer KW: Cerebral resuscitation in the treatment of near drowning. *Wilderness Medicine* 1987; 4 (#3): 5.
31. Kizer KW: Aquatic medicine. *Annals of Emergency Medicine* 1987; 16: 999.
32. Kizer KW: AIDS - know the facts. *California Chiropractic Journal.* August 1987. pp 23-25.
33. Kizer KW and Ellis A: C-section rate related to payment source. *American Journal of Public Health* 1988; 78: 96-97.
34. Kizer KW: Guidelines for HIV testing. *California Physician* 1988; 5 (#1): 30-31. Adapted and printed in the California Board of Medical Quality Assurance *Action Report* 1988 (August); pp 1-2.
35. Kizer KW, Ault T and Olivas J: Record increase of syphilis in California. *Western Journal of Medicine* 1988; 148: 94-95.
36. Kizer KW and Green M: California's male suicide rate at record high. *Western Journal of Medicine* 1988; 148: 95.
37. Kizer KW: Summary statement on the CDHS AIDS and Drug Abuse Workshop. *California AIDS Update* 1988; 1 (#3): 17-18.
38. Kizer KW: Inequivalence of sustained release theophylline products: findings of a California survey. *Immunology & Allergy Practice* 1988; X: 375-377.
39. Kizer KW, Richardson SE and Pond EM: New state program puts experimental drugs on fast track: California's drug and medical device review program. *California Physician* 1988;5 (#12): 26-29.
40. Kizer KW, Green M, Perkins CA, Doebbert G and Hughes MJ: AIDS and suicide in California. *Journal of the American Medical Association* 1988; 260:1881.
41. Kizer KW: California battles AIDS. *California County* July-August 1988; p 20.
42. Harrison R, Bellows J, Rempel D, Rudolph LH, Kizer KW, Jin A, Guglielma J, and Bernard BB: Assessment exposures of health care personnel to aerosols of Ribavirin - California. *Morbidity and Mortality Weekly Report.* 1988; 37: 560-563.
43. Kizer KW and Dumbauld S: Recent trends in lung and breast cancer mortality in California women. *Western Journal of Medicine* 1988; 149: 466467.
44. Kizer KW: The health agenda: cost, access and quality. *State Government News* December 1988; 31:10-11.
45. Kizer KW: *Pasteurella multocida* infection complicating a cougar bite. *Wilderness Medicine* 1988; 5 (#4): 5-6.

46. Kizer KW: Human plague in California. *Wilderness Medicine* 1989; 6 (#1): 7.
47. Kizer KW, Fergusan SC and Harris JA: California's birth defects monitoring program: An important new medical resource. *California Physician* 1989; 6 (#4): 3841.
48. Kizer KW: Ferrets: domestic or feral? *Wilderness Medicine* 1989; 6 (#2): 12.
49. Kizer KW: Study raises concerns about exposure of health workers to antiviral ribavirin. *Action Report* 1989 (#36): 2.
50. Kizer KW and Constantine DG: Pet ferrets: a hazard to public health and wildlife. *Western Journal of Medicine* 1989; 150: 466.
51. Kizer KW: Radon contamination of California homes. *California Physician* 1989; 6 (#6):35-37.
52. Kizer KW: Health hazard of clove cigarettes. *Journal of the American Medical Association* 1989; 261: 2635.
53. Kizer KW: Radon testing of California homes. *Western Journal of Medicine* 1989; 150:697-698.
54. Kizer KW and Poorbaugh JH: -Miraculous insecticide chalk": an unregistered household pesticide. *Western Journal of Medicine* 1989; 150: 698.
55. Kizer KW: HIV disease and emergency medicine (Epitomes in Emergency Medicine). *Western Journal of Medicine* 1989; 151: 6566.
56. Pendergast T, Peck B. Jackson R and Kizer KW: Endrin poisoning associated with taquito ingestion - Orange County, California. *Morbidity and Mortality Weekly Report* 1989; 38:345-347.
57. Kizer KW, Warriner TE and Book SA: A case report on California's Proposition 65 - author's response. *Journal of the American Medical Association* 1989; 261: 2501.
58. Kaplan G, Wright W and Kizer KW: Smoking attributable morbidity, mortality and economic costs - California. *Morbidity and Mortality Weekly Report* 1989; 38: 272-275.
59. Trachtenberg AI, Capell FJ, Vugia DJ, Ascher MS and Kizer KW: Neonatal prevalence of anti-Human Immunodeficiency Virus antibodies in California. *Pediatrics* 1989; 84: 745-746.
60. Hughes MJ, Winter SL, Perkins CI, Kizer KW, Capell FJ and Trachtenberg AI: Prevalence of HIV antibody among blood donors in California. *New England Journal of Medicine* 1989; 321:974-975.
61. Cain DP, Plummer CC, Cook DB, Nyland HS, Surdyke JE, Stephens BG, Jensen PB, Gossett NL, Hauser JE, Noran AF, Martel SJ, Toppozada TR, Trent RB, Stratton JW, Mortenson DC, Kreutzer RA, Goldman LR, Acree KH, Lyman DO and Kizer KW: Earthquake-associated deaths. *Morbidity and Mortality Weekly Reports* 1989; 38: 767-770.
62. Kizer KW: Health: A prescription for equity. *California Journal* 1990; 21: 55-59.
63. Goldman LR, Schlag RD, Haan M and Kizer KW: Preventing lead poisoning in children (Epitomes of Preventive Medicine and Public Health). *Western Journal of Medicine* 1990; 152:289-290.
64. Heikoff L, Ellis K, Garona JE, Deerfield R, Casey A, Mendell MJ, Saunders TM, Willits DG, Goldman LR and Kizer KW: Clinical spectrum of eosinophilia-myalgia syndrome--California. *Morbidity and Mortality Weekly Report* 1990; 39: 89-91.
65. Kizer KW, Felten JA, Jodar VA, Yamamoto HE and Montes JM: Integration of STD and HIV prevention efforts. *Western Journal of Medicine* 1990; 152: 428-429.
66. Kizer KW, Abbott DD and Trent RB: Response to the Loma Prieta earthquake. *Journal of Wilderness Medicine* 1990; 1: 213-216.
67. Kizer KW, Hayward SB and Liu KS: Radon in California homes. *Western Journal of Medicine* 1990; 153: 446-447.
68. Alexeeff GV, Lipsett MJ and Kizer KW: IDLH values - author's response. *Americana Industrial Hygiene Association Journal*; 1990; 51: 688692.
69. Dyer JE, Kreutzer R, Quattrone A, Kizer KW, Geller RJ, Smith JD, Normann SA, Hill M, Calder RA, Litovitz T, US FDA and CDC: Multistate outbreak of poisonings associated with illicit use of gamma hydroxy butyrate. *Morbidity and Mortality Weekly Report* 1990; 39:381-383.
70. Kizer KW: An agenda for public health in the 1990's. *Western Journal of Medicine* 1991; 154:471-472.
71. Kizer KW, Goldman LR, Haan M, Flattery J and Schlag RD: Children and lead: a statewide concern. *California Physician* 1991; 8 (#3): 50-53.
72. Shusterman D, Liu KS and Kizer KW: Carbon monoxide poisoning. *Western Journal of Medicine* 1991; 154: 737.
73. Kizer KW: Regulations for raw oysters. *Wilderness Medicine Letter* 1991; 7 (#2): 12.
74. Kizer KW: The menace of alcohol - author's response. *Western Journal of Medicine* 1991;155: 430.
75. Kizer KW: California's cancer reporting system. *California Physician* 1992; 9(#3): 4649.

76. Kizer KW: Diving computers and recreational diving. *The Journal of Wilderness Medicine* 1994; In press.
77. Kizer KW: *Vibrio vulnificus* infections and raw oysters. *American Journal of Preventive Medicine* 1994; 10:123-124.
78. Kizer KW: Report on the Wilderness Risk Manager's meeting. *Wilderness Medicine Letter* 1994; 11(#1): 13.
79. Kizer KW: Wilderness medicine. *Journal of Family Practice* 1994; 38:10.
80. Kizer KW, Moran ME, Vassar M: Apparent loss of sexual discrimination in the incidence of urolithiasis in California. *Medical Journal of Australia*. 1994; 160:448.
81. Kizer KW: Domoic acid poisoning (Epitomes in Preventive Medicine) *Western Journal of Medicine*. 1994; 161:59-60.
82. Kizer KW: *Vibrio vulnificus* hazard from raw oysters (Epitomes in Preventive Medicine) *Western Journal of Medicine*. 1994; 161:6465.
83. Kizer KW, Pelletier KR, Fielding JE: Worksite health promotion and health system reform. *Western Journal of Medicine*. Submitted for publication.
84. Hughes M, Sage A, Kizer KW: Primary care and the AIDS/HIV Disease. *Journal of Family Practice*; In press.
85. Rozance CP, Kizer KW: AIDS and older persons. Submitted for publication.
86. Kizer KW, Boone HA, Heneveld E, Orozco JR: Nail gun injury to the heart. *Journal of Trauma*; Submitted for publication.

LIMITED CIRCULATION MONOGRAPHS AND PROJECT REPORTS

1. Kizer KW: "Cross-Modal Integration Phenomena in Macaque Monkeys" (Senior undergraduate honors thesis), 1972. On file in Falconer Library, Department of Biological Sciences, Stanford University.
2. Kizer KW: "Guidelines for the Medical Care of Workers Injured by the Le Fiell Air Powered Cattle Stunning Gun, Model 83 Series". Prepared for the Le Fiell Company, San Francisco, 1983.
3. Kizer KW, Moorhead GV and Freeman C: *The Status of Emergency Medical Services Systems Development in California: Initial Report to the Legislature*. California Emergency Medical Services Authority, Sacramento, 1984.
4. Kizer KW, Moorhead GV and McNeil M: *Emergency Medical Services Systems Standards and Guidelines: Part I - General Standards and Guidelines*. California Emergency Medical Services Authority, Sacramento, 1984.
5. Kizer KW, Huntley JC and Moorhead GV: *Grant Program Management and Reporting Manual*. California Emergency Medical Services Authority, Sacramento, 1984.
6. Kizer KW, Lan D and Freeman C: *Disaster Contingency Plan for the Acquisition and Distribution of Blood and Blood Products*. California Emergency Medical Services Authority, Sacramento, 1984.
7. Pierce SC, Aved BM, Kizer KW, Fraziear T and Rodriguez J: *The Monterey County Health Initiative 1980-1985: A Preliminary Analysis*. California Department of Health Services, Sacramento, 1985.
8. Kizer KW, Rodriguez J, McHolland GF and Weller W: *A Quantitative Analysis of AIDS in California*. California Department of Health Services, Sacramento, 1986.
9. Kizer KW (ed): *Acquired Immune Deficiency Syndrome in California: A Prescription for Meeting the Needs of 1990*. California Department of Health Services, Sacramento, 1~6.
10. Goldman L, Stratton J, Kizer KW and Kelter A: *California's Fourth of July Food Poisoning Epidemic from Aldicarb Contaminated Watermelons*. California Department of Health Services, Sacramento, 1986.
11. Spain C, Eastman EM and Kizer KW: *State and Local Health Agency Implementation of Model Standards for Community Health Services: An Evaluation of Impact on Local Health Agency Performance. Phase I Report*. A report to the Centers for Disease Control, U.S. Public Health Service (Contract #200-830606), 1986.
12. Austin DF and Kizer KW: *Cancer Incidence Rates for the San Francisco - Oakland Metropolitan Statistical Area 1980-84*. Cancer in California, Technical Report No. 1. California Department of Health Services, Emeryville, 1987.
13. Spain C, Eastman EM and Kizer KW: *State and Local Agency Implementation of Model Standards for Community Preventive Health Services: An Evaluation of Impact on Local Health Agency Performance. Final Report.* A report to the Centers for Disease Control, U.S. Public Health Service (Contract #200-830606), 1987.
14. Austin DF and Kizer KW: *Cancer Incidence Rates for Alameda. Contra Costa. Marin. San Francisco and San Mateo Counties 1980-84*. Cancer in California, Technical Report No. 2. California Department of Health Services, Emeryville, 1987.

15. Kizer KW, Rodriguez J and McHolland GF: *An Updated Quantitative Analysis of AIDS in California*. California Department of Health Services, Sacramento, 1987.
16. Johnson LF, Glazer ER, Austin DR and Kizer KW: *The Incidence of Childhood Cancer in the San Francisco-Oakland Metropolitan Statistical Area 1970-84*. Cancer in California, Technical Report No. 3. California Department of Health Services, Emeryville, 1987.
17. Gold EB, Nelson VE, Austin DF and Kizer KW: *Cancer and non-cancer mortality in Humboldt County. 1980-1985*. California Department of Health Services, Emeryville, 1988.
18. Lloyd J and Kizer KW: *Severe AIDS Related Conditions in California*. California Department of Health Services, Sacramento, 1988.
19. Kizer KW, Conant MA, Frances DP and Fraziear T: *AIDS Prevention and Treatment: A Framework for Local Planning*. California Department of Health Services, Sacramento, 1988.
20. Kizer KW: "A Proposal to Improve Access to Obstetrical Care in California". California Department of Health Services, Sacramento, 1988.
21. Kizer KW and Rodriguez JR: *Cost Containment in Medi-Cal: Current and Historical Perspectives*. California Department of Health Services, Sacramento, 1988.
22. Kizer KW and Fraziear T (eds): *Guidelines for the Voluntary Notification of Sex and Needle/Syringe-Sharing Partners of Persons with Human Immunodeficiency Virus Infection*. California Department of Health Services, Sacramento, 1988.
23. Constantine DG and Kizer KW: *Pet European Ferrets: A Hazard to Public Health. Small Livestock and Wildlife*. California Department of Health Services, Sacramento, 1988.
24. Nelson VE, Palmer L, Wi S, Austin DA and Kizer KW: *California Cancer Mortality Rates, 1980-1984*. Cancer in California, Technical Report No. 4. California Department of Health Services, Emeryville, 1988.
25. Kizer KW, Keith J, Hiehle G, Wolcott C and Maxfield B: *AIDS in California: Expenditures, Demographics and Mortality for Persons with AIDS on Medi-Cal*. California Department of Health Services, Sacramento, 1988.
26. Kizer KW and Eastman EM (eds): *Proceedings of the California Department of Health Services Workshop on HIV Infection and IV Drug Use*. California Department of Health Services, Sacramento, 1988.
27. Singleton JA, Perkins CI, Trachtenberg AI, Hughes M and Kizer KW: *HIV Seroprevalence among Prisoners Entering the California Correctional System*. California Department of Health Services, Sacramento, 1989.
28. Harris JA and Kizer KW: *Rules for Public Access to California Birth Defects Monitoring Program Data*. California Department of Health Services, Emeryville, 1989.
29. Hughes MJ, Perkins CI, Capeli FJ, Singleton JA, Trachtenberg AI, Kizer KW, Anderson RE, Francis DP, Wilson MJ and Lloyd JC: *The Prevalence of Antibodies to HIV-1 in California Public Health. Drug Treatment and Jail Settings*. California Department of Health Services, Sacramento, 1990.
30. Kizer KW, Wright WE, Kohatsu ND, Luckmann R, Acree KH, Fuhs GW, Felten PG and Shaw J: *Screening for Markers and Risk Factors for Chronic Health Conditions: Recommendations for the use of biochemical screening tests in the community setting*. California Department of Health Services, Berkeley, 1989.
31. Kizer KW, Truax SR, Ramirez A and Fraziear T: *California's HIV Alternative Test Site Program:The First Four Years*. California Department of Health Services, Sacramento, 1989.
32. Price DW and Kizer KW: *California's Paralytic Shellfish Poisoning Prevention Program 1927-1989*.California Department of Health Services, Sacramento, 1990.
33. Kizer KW and Abbott D: *Response to the Loma Prieta Earthquake*. California Department of Health Services, Sacramento, 1990.
34. Hiehle G, Maxfield WT and Kizer KW: *Medi-Cal Studies in AIDS: Demographics and Expenditures for Persons with AIDS. 1980-1989*. California Department of Health Services, Sacramento, 1990.
35. Wolcott CM, Maxfield WT and Kizer KW: *Medi-Cal Studies in AIDS: Intravenous Drug Users: Characteristics Trends and Expenditures. 1980- 1989*. California Department of Health Services, Sacramento, 1990.
36. Goldman LR, Stephens RD, Borzelleri R and Kizer KW: Dioxins: A Widespread Problem in California. California Department of Health Services, Sacramento, 1991.
37. Richards RT and Kizer KW: A Social Impact Assessment of the Dunsmuir Metam Sodium Spill. A report prepared for the California Policy Seminar, University of California. Berkeley, 1992.
38. Kizer KW, Vassar MJ: Fatalities in BSA-sponsored outdoor sports activities: 1980-1992. A report prepared for the Boy Scouts of America. 1993.
39. Kizer KW: Fatalities and serious injuries in BSA-sponsored winter sports activities: 1980-1993. A report prepared for the Boy Scouts of America. 1994.

40. Kizer KW: Determining medical fitness for scuba diving: a general approach with some specific recommendations. A report prepared for the Boy Scouts of America. 1994.

ABSTRACTS, POSTERS AND ORIGINAL PAPERS

1. Kizer KW: Dysbarism in paradise: the epidemiology and clinical characteristics of decompression sickness and arterial gas embolism in Hawaii, 1976-1978. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. San Francisco, California. September 15-16, 1979.
2. Kizer KW: Dysbarism in paradise - case reports. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. San Francisco, California. September 15-16, 1979. Published in: *Proceedings of the Meeting of the North Pacific Chapter of the Undersea Medical Society*, Undersea Medical Society. Bethesda, Maryland. 1980. pp 65-74.
3. Kizer KW: Statistical analysis of diving accidents in Hawaii, 1976-1979. Presented to Diving Medicine '80, University of Hawaii School of Medicine. Kailua-Kona, Hawaii. May 23-29, 1980.
4. Kizer KW: Computerized tomography in the post-recompression management of dysbarism. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Avalon, California. October 2-3, 1980.
5. Kizer KW: Corticosteroids in the treatment of serious decompression sickness. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Avalon, California. October 2-3, 1980.
6. Kizer KW: Delayed recompression treatment of dysbarism. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Avalon, California. October 2-3, 1980.
7. Kizer KW: Epidemiologic and clinical aspects of dysbaric diving accidents in Hawaii, 1976-1979. Presented to the Sixth Annual Conference on the Clinical Application of Hyperbaric Oxygen. Long Beach, California. June 13-IS, 1981. Recorded by Info-Medix. Garden Grove, California.
8. Kizer KW: Neurological manifestations of decompression sickness. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Portland, Oregon. October 22-23, 1981.
9. Kizer KW, Kram J and Dobbs L: Hyperbaric oxygen treatment of necrotizing rheumatoid vasculitis. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Portland, Oregon. October 22-23, 1981.
10. Kizer KW: Dysbaric air embolism in Hawaii. Presented to the Seventh Annual Conference on the Clinical Application of Hyperbaric Oxygen. Long Beach, California. June 9-11, 1982. Recorded by Info-Medix. Garden Grove, California.
11. Kizer KW, Kram J and Dobbs L: Hyperbaric oxygen therapy of refractory skin ulcers. Presented to the Seventh Annual Conference on the Clinical Application of Hyperbaric Oxygen. Long Beach, California. June 9-11, 1982. Recorded by Info-Medix. Garden Grove, California. Abstract published in *HBO Review* 1983; 4:91.
12. Kizer KW: Monoplace chamber treatment of decompression sickness. Presented to the Annual Scientific Meeting, North Pacific Chapter, Undersea Medical Society. Vancouver, British Columbia, Canada. November 56, 1982.
13. Kizer KW: Drugs and diving. Published in: Bangassar R and Bangassar S (eds), *Proceedings of the Thirteenth International Conference on Underwater Education*, National Association of Underwater Instructors. Montclair, California. 1983.
14. Kizer KW: The state perspective on primary care case management. Published in: Coastal Research Group, *Proceedings of the Primary Care Case Management Conference*, St. Mary Hospital Medical Center. Long Beach, California. May 17-18, 1985. pp 129-135.
15. Auerbach PS, Yajko D, Hadley K and Kizer KW: Antibiotic sensitivity of bacteria isolated from the marine environment: implications for clinical therapy. Presented to the 1985 Joint Conference - Undersea Medical Society Annual Scientific Meeting and The Tenth Annual Conference on Clinical Applications of Hyperbaric Oxygen. Long Beach, California. June 12-14, 1985.
16. Kizer KW, Russell JC and Eastman EM: Model standards implementation: a test-contra assessment in California. Presented to the 113th Annual Meeting, American Public Health Association. Washington, D.C. November 18, 1985.
17. Kizer KW: Drugs and diving - an update. Published in: Bangasser S (ed), *Proceedings of the International Conference on Underwater Education*, National Association of Underwater Instructors. Montclair, California. 1985. pp 219-228.

18. Kizer KW: Shark attack - managing the injury. Published in: Bangasser S (ed), *Proceedings of the International Conference on Underwater Education*, National Association of Underwater Instructors. Montclair, California. 1985. pp 229-232.
19. Kizer KW: California's implementation of public policy in the prevention and control of AIDS. Published in: *AIDS - Public Policy and Social Concerns*, Conference Proceedings, University Extension and School of Medicine, University of California, Davis, California. June 16,1986. pp 16-18.
20. Kizer KW: Trends in government supported health care affecting child health care programs. Published in: *Proceedings of the Pediatric Critical Care Symposium*, September 12, 1986. Pediatric Intensive Care Network of Northern and Central California. Santa Cruz, California. 1987. pp 3943.
21. Eastman E, Spain CL and Kizer KW: Public health model standards research and demonstration in California: interim report of findings. Presented to the 114th Annual Meeting of the American Public Health Association. Las Vegas, Nevada. September 28-October 2, 1986.
22. Kizer KW: Cost-quality balance in public programs. Presented to the 114th Annual Meeting of the American Public Health Association. Las Vegas, Nevada. September 28-October 2, 1986.
23. Kizer KW: Long term care: liability issues. Published in: *Whittier Law Review* 1986; 8: pp 353-357.
24. Auerbach PS, Yajko D, Nassos P and Kizer KW: Bacteriology of the aquatic environment. Presented to the Fourth Annual UA/EM- IRIEM Research Symposium: Environmental Emergencies. Tampa, Florida. February 22-24, 1987.
25. Kizer KW: *Pasteurella multocida* infection complicating a cougar bite. Presented to the Third Annual Scientific Meeting of the Wilderness Medical Society. Aspen, Colorado. August 26, 1987. Abstract published in *Wilderness Medicine* 1988; 5(#4): 4-5.
26. Kizer KW: Proposed regulation of scuba diving in California: a misguided effort. Published in: Slaybe C (ed), *Proceedings of the International Conference on Underwater Education*, National Association of Underwater Instructors. Montclair, California. 1987. pp 269-271.
27. Kizer KW: Sexually transmitted diseases in California. Published in: *Taking a Sexual History:1988*, Conference Proceedings; April 7, 1988. California Area Health Education Center System and the California Department of Health Services. Fresno, California. 1988. pp 2-12.
28. Bye L, Capell F, Anderson R, Henne J, Kizer KW and Francis DP: Prevalence of AIDS risk factors in the population of the state of California. Poster, presented to the Fourth International Conference on AIDS. Stockholm, Sweden. June 12-16, 1988.
29. Goldman LR, Haan MN, Jackson RJ and Kizer KW: The California childhood lead poisoning prevention program: does California have a lead exposure problem? Presented to the 115th Annual Meeting of the American Public Health Association. Boston, Massachusetts. November 13-17, 1988.
30. Kizer KW, Cunningham G, Lustig L and Stoner E: One year experience in statewide MSAFP screening. Presented to the 115th Annual Meeting of the American Public Health Association. Boston, Massachusetts. November 13-17, 1988.
31. Kizer KW: Economic impact of HIV infection in California. Presented to the International Invitational Conference on the Economic Impact of HIV Infection; McGill Centre for Medicine, Ethics and Law. Montreal, Quebec, Canada. November 29-30, 1988.
32. Wilson MJ, Greenhalgh JB, Lemp GF, Perkins CI, Kizer KW and Rutherford GW: HIV seroprevalence surveys in the San Francisco Bay Area. Presented to the Fifth International Conference on AIDS. Montreal, Canada. June 5-9, 1989.
33. Capell FJ, Mordaunt VL, Vugia DJ, Ascher MS, Marelich W, Trachtenberg AI and Kizer KW: Distribution of HIV infection among childbearing women in California: results from the first wave of unlinked neonatal HIV screening. Presented to the 5th National Pediatric AIDS Conference. Los Angeles, California. September 6-8, 1989.
34. Kizer KW: Autochthonous transmission of introduced malaria in California. Presented to the 5th Annual Scientific Meeting of the Wilderness Medical Society. Stratton, Vermont. September 24-28, 1989. Abstract published in *Wilderness Medicine Letter* 1990; 7(2): 12.
35. Kizer KW: Medicare Catastrophic Coverage Act of 1988 - concerns for the states. Presented to the Annual Meeting of the Association of State and Territorial Health Officials. Vail, Colorado. April 4-7, 1989. Published in: *Association of State and Territorial Health Officials 1989-90 Annual Report*. ASTHO. McLean, Virginia. 1989. pp 11-12.
36. Kizer KW: California confronts AIDS. Presented to the 2nd National AIDS Conference. San Francisco, California. Published in: *Proceedings of The 2nd National AIDS Conference*. Health Officers Association of California and the San Francisco Department of Public Health. San Francisco, California. 1989.
37. Trachtenberg AI, Creeger JN, Capell FJ, Hughes M and Kizer KW: AIDS-related Kaposi's sarcoma in California: regional incidence and mortality trends. Presented to the California

Cancer Registries Conference: Cancer Control by the Year 2000? Controversies and Challenges. Los Angeles, California. February 27-28, 1990.

38. Price DR, Kizer KW, and Hansgen KH: Toxic dinoflagellate blooms and paralytic shellfish poisoning in California, 1927-1989. Presented to the Joint Annual Meeting of the National Safe Fisheries Association and the Safe Fisheries Institute of North America. Williamsburg, Virginia. April 1-5, 1990.
39. Kizer KW: Lessons from disasters-the Loma Prieta earthquake. Presented to the Annual Meeting of the Association of State and Territorial Health Officials. Charleston, South Carolina. April 30-May 2, 1990.
40. Kizer KW: Health care reform - future directions. Presented to the Society for Academic Emergency Medicine Annual Meeting. Minneapolis, Minnesota. May 22, 1990.
41. Kizer KW and Cunningham G: Newborn screening for AIDS and hepatitis: implementation and health policy issues. Presented to the Satellite II of the Vth International Congress of Inborn Efforts of Metabolism. San Francisco, California. May 29-31, 1990.
42. Kizer KW, Margolis HG, Hughes M and Fraziear T: California's program to promote private industry involvement in HIV vaccine research and development. Poster, presented to the Sixth International Conference on AIDS. San Francisco, California. June 20-24, 1990.
43. Marelich WD, Ramirez AL, Barba B and Kizer KW: Support system availability of clients utilizing anonymous HIV antibody test sites in California. Poster, presented to the Sixth International Conference on AIDS. San Francisco, California. June 20-24, 1990.
44. Wilson MJ, Marelich WD, Lemp GF, Perkins CI, Kizer KW and Rutherford GW: HIV seroprevalence surveys in sexually transmitted disease clinics in California. Poster, presented to the Sixth International Conference on AIDS. San Francisco, California. June 20-24, 1990.
45. Hughes M, Guzman R, Jain S and Kizer KW: A pilot program to provide communicable disease screening services in drug treatment program settings. Poster, presented to the Sixth International Conference on AIDS. San Francisco, California. June 20-24, 1990.
46. Carpenter PF, Conant MA, Francis DP, Kizer KW and Werdeger D: From the eye of the hurricane--a multidisciplinary AIDS strategy for the 1990s. Presented to the Sixth International Conference on AIDS. San Francisco, California. June 20-24, 1990.
47. Rhee KJ, Albertson TE and Kizer KW: The HIV-1 seroprevalence rate of injured patients admitted through California emergency departments. Presented to the Annual Scientific Meeting of the American College of Emergency Physicians. San Francisco, California. September 16-19, 1990
48. Smith MW, Kreutzer R, Goldman LR and Kizer KW: Access to care in a rural California agricultural town. Presented to the 118th Annual Meeting of the American Public Health Association. New York, New York. September 30-October 4, 1990.
49. Kizer KW: Improving access to affordable health care; response to Senator John Kitzhaber. Presented to the Richard and Hinda Rosenthal Lectures, sponsored by the Institute of Medicine, National Academy of Sciences. Irvine, California. January 22, 1990. Published in: *Improving Access to Affordable Health Care*, Institute of Medicine. Washington, D.C. 1990. pp 81-85.
50. Kizer KW, Price DW and Hansgen KH: California's paralytic shellfish poisoning prevention program. Presented to the Fifth International Conference on Toxic Marine Phytoplankton. Newport, Rhode Island. October 28-November 1, 1991.
51. Kizer KW: (1) Clinical manifestations and treatment of paralytic shellfish poisoning, and (2) Preventing paralytic shellfish poisoning. Presented to the International Scientific Symposium on Red Tide Phenomenon sponsored by the Universidad de Maritima de Chile and the Armada de Chile. Vina del Mar, Chile. May 15-16, 1992.
52. Kizer KW: Alcohol-related mortality in California. Presented to the Potential Health Effects of Components of Plant Foods and Beverages in the Diet Workshop, sponsored by the University of California, Davis, College of Agricultural and Environmental Sciences and School of Medicine. Davis, California. August 14, 1992. Published in *Proceedings. Potential Health Effects of Components of Plant Foods and Beverages in the Diet*, University of California, Davis. Davis, California. 1993. pp 1-5.
53. Kizer KW: Naturally occurring biotoxins in seafood - growing concerns. Presented to the Food-Borne Diseases Lectureship and Workshop, University of California, Davis. January 8, 1993. Published in: *Proceedings of the Food-Borne Diseases Lectureship and Workshop*. 1993. pp 27-29.
54. Moran ME, Vassar MJ and Kizer KW: Changing stone incidence patterns in California: the loss of sexual discrimination. Abstract, Presented to the ROCK Society Annual Meeting. Dallas, Texas. January 23, 1993.
55. Kizer KW, Nesbitt T, Ziewacz J and Logan JS: The Need for alternative policies and funding sources for rural health services. Presented to the Cooperative Solutions to Rural Health Care Problems: Emergency Medical Services Conference, Sacramento, California, June 24, 1993.

In:Gray D. (editor): *Cooperative Solutions to Rural Health Care Problems: Emergency Medical Services*. UCD Center for Cooperatives, 1993, pp 45-50.

56. Kizer KW: Tree-well asphyxiation in snowboarders. Presented to the 9th Annual Scientific Meeting of the Wilderness Medical Society. Big Sky, Montana. August 8-13, 1993. Published in the *Journal of Wilderness Medicine* 1994; 5:199.
57. Kizer KW: Scuba diving deaths following designation of an underwater park at Lake Tahoe. Presented to the 9th Annual Scientific Meeting of the Wilderness Medical Society. Big Sky, Montana. August 8-13, 1993. Published in the *Journal of Wilderness Medicine* 1994; 5:199.
58. Kizer KW: Anaphylactic deaths from Triatoma bites. Presented to the 9th Annual Scientific Meeting of the Wilderness Medical Society. Big Sky, Montana. August 8-13, 1993. Published in the *Journal of Wilderness Medicine* 1994; 5:200.
59. Langlois GW, Kizer KW, Hansgen K, Howell R and Loscutoff S: Distribution and magnitude of domoic acid in California coastal molluscs and crabs. Published in the book of Abstracts and Posters of the 6th International Conference on Toxic Marine Phytoplankton. Nantes, France. October 18-22, 1993.
60. Langlois GW, Kizer KW, Smith P, Hansgen KH and Howell R: Preliminary results of the California phytoplankton monitoring program. Published in the book of *Abstracts and Posters of the 6th International Conference on Toxic Marine Phytoplankton*. Nantes, France. October 18-22, 1993.
61. Smith MW, Kreutzer RA, Goldman L, Casey A and Kizer KW: How economic factors influence access to medical care for children in a rural latino community. Presented to the 121st Annual Meeting of the American Public Health Association. San Francisco, California. October 24-28, 1993.
62. Dales LG, Rutherford GW, Woodford G, Kizer KW and Nelson MJ: California's 1988-1990 measles epidemic: impact of low vaccine coverage. Presented to the 121st Annual Meeting of the American Public Health Association. San Francisco, California. October 24-28,1993.
63. Ruiz J, Flynn N, Anderson R, Hughes M, Watters J, Kizer K: Rapid inexpensive method for assessing HIV rates and risk of HIV transmission among IDU. Abstract. Presented to the Tenth International Conference on AIDS. Yokohama, Japan. August 7-12, 1994.
64. Vassar MJ, Kizer KW: Hospitalization charges for 9,722 firearm injuries in California during 1991. To be presented to the 122nd Annual Meeting of The American Public Health Association. Washington, D.C. October 30 - November 3, 1994.

SELECTED KEYNOTE, FEATURED SPEAKER AND RECORDED PRESENTATIONS

1. Kizer KW: New directions for emergency medical services. Presented to the Annual Statewide Conference of the California Emergency Services Association. Anaheim, California. May 11, 1984.
2. Kizer KW: Future directions in public health in California. Presented to the Annual Meeting of the California Conference of Local Health Department Nursing Directors. Monterey, California. September 17, 1984.
3. Kizer KW: California's environmental health priorities. Presented to the Annual Meeting of the California Conference of Directors of Environmental Health. Bakersfield, California. September 18, 1984.
4. Kizer KW: Future directions of health care in California. Presented to the California Medical Association and San Joaquin Counties Postgraduate Institute. Yosemite, California. February 28, 1985.
5. Kizer KW: The status of hospital contracting and capitation in California. Presented to the California Hospital Association's Annual Legislative Session. Sacramento, California. April 17, 1985.
6. Kizer KW: Turning to prevention. Presented to the California Area Health Education Center System Statewide Conference. Sacramento, California. May 7-8, 1985.
7. Kizer KW: Competitive market forces: California's approach to harnessing health care costs. Presented to the 1985 National Medicare and Medicaid Conference, sponsored by the U.S. Department of Health and Human Services, The Health Care Financing Administration, and others. Los Angeles, California. June 19-21, 1985.
8. Kizer KW: Future directions of health care in California. Presented to the Annual Meeting of the California Society of Internal Medicine. Coronado, California. June 21-23, 1985.
9. Kizer KW: Emerging health issues of the 80's and 90's. Presented to the Joint Chiefs of Staff Medical Commissioners Annual Meeting. Vandenberg Air Force Base, California. June 25, 1985.
10. Kizer KW: Preparing for the Public Health Challenges of the 1990s. Lester Breslow Distinguished Lectureship; University of California, Los Angeles, School of Public Health. April 17, 1986.

11. Kizer KW: Rural health care issues in California. Presented to the Annual Meeting of the National Rural Health Care Association. May 21, 1986.
12. Science in the Formulation of Public Policy. Commencement Speech, College of Science, Humbolt State University. June 12, 1986.
13. Kizer KW: Assuring quality in long term care. Presented to the California Association of Health Facilities Annual Meeting. Orange, California. August 17-19, 1986.
14. Kizer KW: The state looks at quality. Presented to the Annual Meeting of the American College of Utilization Review Physicians. San Diego, California. October 24, 1986
15. Kizer KW: Implementation of Proposition 65. Presented to the "Doing Business After Proposition 65..." Conference, sponsored by the California Chamber of Commerce, California Manufacturers Association and others. Sacramento, California. December 18, 1986.
16. Kizer KW: Implementation of California's Proposition 65. Presented to the American Industrial Health Council. Washington, D.C. May 20, 1987.
17. Kizer KW: Medical education in an era of health care cost containment. Presented to the Annual Medical Staff Meeting and Awards Ceremony, University of California, San Diego, Medical Center. San Diego, California. June 1, 1987.
18. Kizer KW: The future of medical education in an era of health care cost containment. Presented to the Harbor-UCLA Medical Center Chapter of the National Management Association. Torrance, California. June 2, 1987.
19. Kizer KW: Border health issues and the need for partnership. Presented to the Annual Meeting of the U.S.-Mexico Border Health Association. San Diego, California. June 8, 1987.
20. Kizer KW: The politics and policymaking for California's birth defects monitoring, maternal alpha feto protein, and newborn genetic disease screening programs. Presented to the Public Affairs Forum of the Twenty-seventh Annual Meeting of the Teratology Society. Rancho Mirage, California. June 14-18, 1987.
21. Kizer KW: The future of indigent health care in California. Presented to the 20th Annual Convention and Scientific Assembly of the Golden State Medical Association. Sacramento, California. June 25-28, 1987.
22. Kizer KW: Government spending and health policy. Presented to the Annual Meeting of the California Society of Hospital Pharmacists. Oakland, California. October 9, 1987.
23. Kizer KW: Selective provider contracting, managed care and other program directions for Medi-Cal. Presented to the 52nd Annual Meeting of the California Association of Hospitals and Health Systems. Monterey, California. October 29, 1987.
24. Kizer KW: The State's assessment of competition in health care. Presented to Kaiser Permanente's National Invitational Conference on Assessing Competition in Health Care. San Francisco, California. October 30, 1987.
25. Kizer KW: AIDS - the medical, social and political aspects of a modern epidemic. Presented to a special AIDS Forum, American College of Emergency Physicians, Annual Scientific Meeting. San Francisco, California. November 3, 1987.
26. Visiting Professor/Consultant on the epidemiology and prehospital treatment of motor vehicle trauma. The Joint Board for Postgraduate Medical Education; Riyadh, Saudi Arabia. November 21-24, 1987.
27. Kizer KW: Respondent to Dr. Jeffrey Goldsmith's presentation, "An American myth: The right to health care." California Health Forum, University of Southern California, Public Affairs Center. Sacramento, California. December 3, 1987.
28. Kizer KW: The State's Role in Assuring Quality Health Care. Robert B. Pierce, Sr., M.D., Memorial Lecture, University of California, Davis, School of Medicine. January 28, 1988.
29. Kizer KW: State financing of health care. Presented to the Regional American Assembly Symposium on Cost, Quality and Access to Health Care in California. Newport Beach, California. March 24-27, 1988. Consensus statement published by the Regional American Assembly entitled *Cost, Quality and Access to Health Care in California.*
30. Kizer KW: How California is coping with the AIDS epidemic and the role of public hospitals. Presented to the 7th Annual Conference of the National Association of Public Hospitals. San Diego, California. June 16, 1988.
31. Kizer KW: AIDS: current and future policy issues. Presented to the AIDS: Current Perspectives Symposium, sponsored by the State Bar of California. San Francisco, California. June 24, 1988.
32. Kizer KW, Semerad R and Moore ED: The workforce of the future: issues for state government. Presented to the 1988 Toll Fellowship Program, The Council of State Governments. Lexington, Kentucky. August 29, 1988.
33. Kizer KW: California's planning for the HIV epidemic. Presented to the Second National AIDS Conference. San Francisco, California. September 30, 1988.

34. Kizer KW: Crucial health issues facing California's physicians. Presented to the 116th Annual Session and Western Scientific Assembly of the California Medical Association. Anaheim, California. March 5, 1989.
35. Kizer KW: California's Proposition 99 and state level tobacco control. Presented to the Annual Meeting of the Association of State and Territorial Health Officials. Vail, Colorado. April 5, 1989.
36. Kizer KW: Public Health Challenges of the 1990s. Masters Honors Convocation, Commencement Speech, Graduate School of Public Health, San Diego State University. May 27, 1989.
37. Kizer KW: Prevention of chronic diseases: innovative efforts in California. Fourth National Conference on Chronic Disease Prevention, sponsored by the U.S. Centers for Disease Control, Association of State and Territorial Health Officials, and others. San Diego, California. September 20, 1989.
38. Kizer KW: Future directions in health care: marrying Hispanic culture and values with 21st century technology. Presented to the Fourth Hispanic Medical Congress, California Hispanic American Medical Association. Los Angeles, California. September 21, 1989.
39. Kizer KW: Food safety in the 90's. Presented to the California Grocers Association Annual Meeting. Reno, Nevada. October 1, 1989.
40. Kizer KW: Respondent to Senator John Kitzhaber, M.D., at the Richard and Hinda Rosenthal Lecture "Access to Affordable Health Care", Institute of Medicine, National Academy of Sciences. Irvine, California. January 22, 1990.
41. Kizer KW: Environmental management in the nineties. Presented to the Waste Minimization Conference, California Partnerships, Inc. Long Beach, California. April 20, 1990.
42. Visiting Professor/Consultant on AIDS and health care management, Khabarovsk Regional Health Department and Magadon Research Institute, Soviet Far East, USSR. February 2-9, 1990.
43. Kizer KW: The new public health 1990. Presented to the California Coalition for the future of Public Health Conference. Los Angeles, California. April 24-27, 1990.
44. Kizer KW: A Public Health Agenda for the 1990s. Commencement Speech, School of Public Health, University of California, Los Angeles. June 16, 1990.
45. Kizer KW: California health issues: the realities of resolving the current health care paradox. Presented to the Health Care Industry Executive Summit. Los Angeles, California. August 28, 1990.
46. Kizer KW: Tobacco control: science and politics. Fifth National Conference on Chronic Disease Prevention and Control sponsored by the U.S. Centers for Disease Control, Association of State and Territorial Health Officials, and others. Detroit, Michigan. October 17-19, 1990.
47. Kizer KW: Ethics and responsible care in the 90's. Presented to the Association of Health Facility Licensure and Certification Directors Annual Meeting. San Francisco, California. November 5, 1990.
48. Kizer KW: Resolving the American health care paradox: fiscal and political realities. Adaptive Business Leaders Health Care Forum. Los Angeles, California. December 12, 1990.
49. Kizer KW: Resolving the American health care paradox. Presented to the Issues Impacting Income Conference. Synergistic Systems, Inc. San Diego, California. August 16, 1991.
50. Kizer KW: Preparing for the challenges of medicine in the 21st century. Presented to the UCLA Department of Family Medicine's Health Policy Colloquium. Los Angeles, California. September 3, 1991.
51. Kizer KW: Health care ethics, value and information management: the tortuous and turbulent road ahead. Presented to the Health Care Information and Management Systems Society (Southern California Chapter) Annual Fall Conference. Manhattan Beach, California. November 15, 1991.
52. Kizer KW: U.S. Health care in the 90's: prospects for the future. Presented to the Orange County Foundation PPO Symposium on U.S. Health Care in the 90's. Anaheim, California. December 4, 1991.
53. Kizer KW: Respondent to Governor Richard Lamm's presentation, "The Brave New World of Health Care." Presented to the California Health Forum, University of Southern California, Public Affairs Center. Sacramento, California. December 4, 1991.
54. Kizer KW: The future of American health care. Presented to the 20th Anniversary Celebration of the UCD Family Nurse Practitioner/Physician Assistant Program, sponsored by the University of California, Davis, Medical Center. Sacramento, California. May 2, 1992:
55. Visiting Professor/Consultant on paralytic shellfish poisoning and marine biotoxins. Universidad Maritima de Chile and Armada de Chile (Chilean Navy). Punta Arenas and Vina del Mar, Chile. May 11-16, 1992.

56. Kizer KW: U.S. health care in the nineties - prospects for reform. Presented to the colloquium Health Reform in Focus: American and Swedish Perspectives, sponsored by the UCSF Institute for Health Policy Studies and the Swedish Information Service. San Francisco, California. May 27, 1992.
57. Kizer KW, Miller J, Stevens C, O'Mara T and Duerr J: The California media campaign: from behind the scenes to an 'on camera' view. Presented to the Revolt Against Tobacco: California Celebrates 3 Years of Progress Conference. Sponsored by the Western Consortium for Public Health, California Tobacco Control Resource Partnership and California Department of Health Services. Los Angeles, California. October 1, 1992.
58. Kizer KW: Cancer in California. Presented to the 12th Annual Meeting of the International Veterinary Cancer Society. Asilomar, Pacific Grove, California. October 18, 1992.
59. Kizer KW: Respondent to Barbara Matula's presentation, "Running in Place: The Race for Health Care Access in America." Presented to the California Health Forum, University of Southern California, Public Affairs Center. Sacramento, California. December 2, 1992.
60. Visiting Professor/Consultant on health care administration and management, Tyumen Regional Health Department, Russia. December 4-9, 1992.
61. Kizer KW: Health care reform and the future financing of emergency medical care. Presented to The 2100 Club, Queen of the Valley Hospital. West Covina, California. December 11, 1992.
62. Kizer KW: U.S. health care in the 21st century: the expanded role of non-physician practitioners. Presented to the 16th Annual Educational Conference of the California Coalition of Nurse Practitioners. Tahoe City, California. April 30, 1993.
63. Kizer KW and Henry GL: The future of specialized treatment centers in the United States: Will the networks survive? Presented to the American College of Emergency Physicians 1993 Scientific Assembly. Chicago, Illinois. October 12, 1993.
64. Kizer KW and Williams RM: Key public policy issues for emergency medicine: the next five years. Presented to the American College of Emergency Physicians 1993 Scientific Assembly. Chicago, Illinois. October 12, 1993.
65. Kitzhaber JA, Kizer KW and Lumpkin JR: State health care reform proposals and their impact on emergency medicine. Presented to the American College of Emergency Physicians 1993 Scientific Assembly. Chicago, Illinois. October 12, 1993.
66. Kizer KW: Prognosis for and implementation of health care reform. Presented to the joint Meeting of the Society of American Value Engineers (Pony Express Chapter) and Society of Mechanical Engineers (Sacramento - Sierra Nevada Section). Sacramento, California. January 20, 1994.
67. Kizer KW: Health system reform and academic medicine. Grand Rounds, Department of Psychiatry, University of California, Davis. Sacramento, California. March 4,1994.
68. Kizer KW: Health care reform in California: lessons for the nation? Issues Impacting Income 5th Annual Conference, Synergistic Systems, Inc. Laguna Beach, California. August 24, 1994.

NOTE

Not listed here are 34 book reviews for professional journals; testimony before State Legislative and U.S. Congressional Committees and Presidential Commissions; 33 tape recorded-for-sale - presentations; more than 100 newspaper and magazine articles; dozens of keynote and grand rounds presentations; and editorial board, contributing editor and similar positions.

WORK EXPERIENCE

July 1991-Present: Professor and Chairman, Department of Community and International Health (DCIH), and Professor, Division of Emergency Medicine and Clinical Toxicology, Department of Internal Medicine; University of California, Davis, School of Medicine. Davis, California

The DCIH is one of 23 departments in the UCD School of Medicine. As Chairman, I am responsible for overseeing numerous academic programs, an annual budget of approximately $7 million, and about seventy staff and faculty, as well as providing instruction to medical, graduate and undergraduate students and conducting research. As a professor of emergency medicine, I attend in the UCD Medical Center Emergency Department and teach in the emergency medicine residency program. I also serve as the Director of the UCD Center for AIDS Surveillance and Epidemiology and Co-Director of the UCD-Dunsmuir Clinic for the Sacramento River spill victims (a court appointed clinic to monitor possible health effects related to the July 1991 Metam Sodium herbicide spill into the Sacramento River at Dunsmuir).

February 1992-Present: Board of Directors, The California Wellness Foundation (TCWF). Woodland Hills, California.

As a Director, and more recently as Chairman of the Board of Directors, of TCWF, I am intimately involved in the management and program development of one of the largest health-related foundations in the country. (Estimated 1994 assets of TCWF are $1 billion.)

March 1985-May 1991: Director, California Department of Health Services. Sacramento, California

In this capacity, I served as the chief health official for the State of California, overseeing (on leaving) a budget of $13 billion and 6,700 employees located in Sacramento and over 160 satellite offices. During my tenure, the Department had responsibility for approximately 150 programs, including many of the most sensitive and visible in government. It was the largest state health department in the U.S. and one of the largest and most complex departments in California State Government.

While I was Director, the four major program areas administered by the Department were Public Health, with programs in all areas of public health; Medi-Cal (the largest Medicaid program in the U.S.); Toxic Substances Control, which administered the State's hazardous materials permitting, site mitigation, alternative technology and related toxics programs (the state EPA function); and Licensing and Certification, which licensed and certified (for Medicare and Medicaid participation) approximately 5,300 health care facilties.

During my tenure, the Department developed and implemented various programs that received national and international acclaim. Among these were the largest birth defects monitoring program in the world, the largest population-based cancer registry in the world, the largest and most aggressive anti-tobacco use campaign ever undertaken, the largest neural tube defects screening program in the world, the most comprehensive food and water testing program in the U.S., a new medical waste management program, a $20 million vital records improvement project, a multi-pronged nutrition program to reduce diet-related diseases that was subsequently adopted by the National Cancer Institute for national implementation, a Medi-Cal Drug Discount and Contract Purchase Program, the award-winning Adolescent Family Life Program, and the most comprehensive state AIDS control program in the U.S. The latter included an innovative program to bring new AIDS drugs to market sooner and the only state funded AIDS vaccine development program.

In addition, the state's nursing home oversight and enforcement program was overhauled, doubling the number of inspectors and more than quadrupling the amount of fines assessed, and the toxic substances control program was reorganized and markedly expanded, including quadrupling the staff, implementing more than 300 new laws and assessing over $25 million in fines and penalties. Similarly, the state's communicable disease reporting requirements were completely revised for the first time in over four decades, the health facility infection control regulations were rewritten for the first time in over twenty years, state sponsored prenatal and children's services were substantially expanded, and several other major revisions of the hospital/health facility regulations were undertaken.

During these years, many infectious disease, toxic waste and other public health emergencies were dealt with, including the largest foodborne pesticide poisoning epidemic in North American history, the McFarland and several other childhood cancer clusters, and fallout from the Chernobyl nuclear power plant accident. Likewise, many legislative and administrative changes were pursued that have led to substantial restructuring of publicly funded health care delivery in California and which have been cited as models for national health care reform.

May 1990-Present: Independent, part-time subcontract emergency physician with North Country Medical Group at Tahoe Forest Hospital. Truckee, California

September 1984-February 1985: Chief Deputy Director for Preventive Health Services, California Department of Health Services. Sacramento, California

In this capacity, I functioned as the Chief of Public Health programs for the State of California. This involved overseeing about 1500 employees, a budget of approximately $1.3 billion, and about 125 distinct programs. Specifically under my purview were the State's public health laboratories; the public drinking water, radiological safety, sanitary engineering, food and drug, and other environmental health programs; health education and risk reduction programs for chronic diseases; the state birth defects and cancer registries; immunization and other communicable disease control programs; the epidemiological studies and environmental risk assessment programs; family planning services; the federally funded WIC supplemental feeding program and other maternal and child health (Title V) programs; the native American and farmworker primary care clinics programs and other rural health services; and the medically indigent services program, county health services program and other local/county health assistance programs.

BOSTON PUBLIC LIBRARY
3 9999 05983 246 7

January 1984-June 1991: Clinical Faculty, Department of Internal Medicine and Department of Community Health, University of California, Davis (UCD), School of Medicine (SOM). Davis, California

I became a member of the UCD SOM Volunteer Clinical Faculty in 1984, when I was appointed as an Assistant Clinical Professor in the Department of Internal Medicine. I was promoted to Associate Clinical Professor in 1988, at which time I also joined the Department of Community Health. My responsibilities involved teaching medical students and housestaff, as well as providing direct patient care on the occupational medicine and emergency medicine services at the UCD Medical Center in Sacramento.

October 1983-August 1984: Director, Emergency Medical Services Authority, State of California. Sacramento, California

The EMS Authority is a freestanding entity within California's Health and Welfare Agency that is charged with planning and coordinating emergency and disaster medical services for the state. I was directly responsible for overseeing a staff of 15 and administering a budget of about $5 million. Among the specific programmatic activities under my purview were promulgation of minimum standards and guidelines for county and regional emergency medical services systems; review and approval of local and regional EMS system plans; development of statewide standards for training and certification of paramedics and other emergency medical technicians, mobile intensive care nurses, and base hospital emergency physicians; development of statewide standards for emergency medical training of lifeguards, firefighters, peace officers and other public safety personnel; development of regulations for regional trauma care systems; development of standards for regional poison control centers; and planning and managing the State's medical response to catastrophic disasters.

January 1983-December 1984: President, Environmental and Emergency Health Services, Inc. (EEHS). Novato, California.

EEHS organized and staffed continuing medical education programs at various locations around the world, especially in wilderness settings, and did a limited amount of consulting.

August 1980-September 1991: Independent, part-time subcontract emergency physician.

During this time, I worked with California Emergency Physicians Medical Group (CEP) in Oakland. The principal CEP contract hospitals I worked at were Samuel Merritt Hospital in Oakland (1980-1984) and Marin General Hospital in Greenbrae (1984-1991), although I also worked a limited amount at St. Catherine's Hospital on Half Moon Bay (Moss Beach) and Mission Oaks Hospital (San Jose).

From August 1980 until October 1983, I also worked for varying periods of time with Marin Emergency Medical Group, Inc., Novato (Novato Community Hospital, Novato); East Bay Emergency Physicians' Association, Castro Valley (Eden Hospital, Castro Valley); Ross Emergency Medical Group, Inc., Novato (Ross General Hospital, Ross); Valley Emergency Physicians, Inc., Berkeley (Corning Memorial Hospital, Corning, and Oak Valley District Hospital, Oakdale); and Emergency Medical Systems, Inc., San Francisco (Ralph K. Davies Medical Center, San Francisco).

July 1982-June 1983: Resident in Occupational Medicine, University of California, San Francisco.

About half of this was spent functioning as a fellow in clinical toxicology in association with the San Francisco Bay Area Regional Poison Control Center and the Division of Clinical Pharmacology and Medical Toxicology at San Francisco General Hospital.

August 1980-September 1983: Consultant in Diving and Hyperbaric Medicine, San Francisco Bay Area and northern California

During this time I evaluated and treated patients in affiliation with: (1) Pulmonary and Critical Care Medical Group, Inc., and the Department of Hyperbaric Medicine at Peralta Hospital, Oakland; (2) the Department of Hyperbaric Medicine at Eden Hospital, Castro Valley; and (3) Ross General Hospital, Ross.

January-June 1982: Associate Physician, Hughes-Lewis Associates, Inc. (HLA). Oakland, California

HLA was a newly formed, multidisciplinary, private practice occupational medicine consulting firm.

July 1980-December 1981: Resident in Diagnostic Radiology, University of California, San Francisco. (I chose to discontinue the residency, after completing half of it, when I decided I did not want a career in diagnostic radiology.)

June 1978-June 1980: Independent, subcontract emergency physician with Hawaii Emergency Physicians Associated, Inc. (HEPA). Kailua, Hawaii.

During this time, I provided emergency physician services at the following HEPA contract hospitals: Kuakini Medical Center, Honolulu; Castle Memorial Hospital, Kailua; Wahiawa General Hospital; Wahiawa; Lucy Henriques Medical Center, Kamuela; and Kona Hospital, Kealakekua.

June 1979-June 1980: Group Medical Officer, U.S. Navy Explosive Ordnance Disposal Group One (EOD GRU ONE). Barbers Point, Hawaii

In this capacity, I was responsible for the provision and/or supervision of health care for the 48 operational fleet and shore commands of EOD GRU ONE, which included a geographic area extending from the Indian Ocean to the Rocky Mountains. Specific responsibilities included managing programs for periodic assessment of fitness for work involving explosives, compressed air and mixed gas diving, and work under very arduous conditions; serving as the Command's alcohol and drug abuse counselor; training Navy hospital corpsmen and EOD personnel in first aid, cardiopulmonary resuscitation, and diving medicine; and performing site visits and health-related inspections at locations where EOD units were operating.

During my tenure at EOD, I also had collateral or additional duty assignments as stand-by diving medical officer, Harbor Clearance Unit One, Pearl Harbor; emergency physician, Barbers Point Navy Branch Clinic; undersea medical officer, Navy Hyperbaric Treatment Center, Pearl Harbor; and general medical officer, U.S. Air Force Branch Dispensary, Enewetok Atoll, Marshall Islands.

January 1978-June 1979: Squadron Medical Officer, Submarine Squadron Fifteen Representative, and Staff Physician, Navy Regional Medical Clinic (NRNIC), Pearl Harbor. Pearl Harbor, Hawaii.

In my capacity as the Squadron Medical Officer for Submarine Squadron Fifteen, and later-as the Acting Squadron Medical Officer for Submarine Squadrons One and Seven also, I was responsible for the provision and/or supervision of health care for a total of 32 submarine crews and their associated shore-based support staff (about 4500 personnel), as well as their dependents occasionally, and for the on-going training and supervision of 35 independent duty hospital corpsmen. Among the specific programs I administered were those for radiological health, weight control, physical fitness, drug and alcohol abuse, immunizations and preventive medicine, and shipboard hygiene.

While assigned to NRMC, Pearl Harbor, I served as a staff physician, providing patient care services in both the emergency department and the general acute care clinic. During my final four months at NRMC I was assigned to develop and manage a Department of Physical and Preventive Medicine, which was charged with performing periodic, special duty and pre-discharge physical examinations on a large number of active duty personnel, administering the immunization program for both active duty and dependent personnel, and overseeing the physical therapy service.

During this time, I had additional or collateral duty assignments as Chief, Ford Island Branch Dispensary; acting staff epidemiologist, Navy Environmental and Preventive Medicine Unit Six, Pearl Harbor; undersea medical officer, Navy Hyperbaric Treatment Center, Pearl Harbor; general medical officer, Midway Branch Dispensary, Midway Atoll; general medical officer, Barking Sands Pacific Missile Tracking Range Branch Dispensary, Kauai; general medical officer, U.S. Army Clinic, Kilauea Military Camp, Volcanoes National Park; medical officer in charge, Pearl Harbor Correctional Center/Joint Armed Services Confinement Facility-Hawaii; and medical officer in charge, Navy Correctional Custody Center, Ford Island.

May 1978-June 1980: Independent medical examiner for numerous life insurance companies in Hawaii.

July 1977-December 1977: Undersea Medical Officer Student, Navy Undersea Medical Institute, and emergency physician, Naval Submarine Medical Center. Groton, Connecticut.

July 1976-June 1977: Intern (rotating internship), Department of Anesthesiology, Naval Regional Medical Center. Portsmouth, Virginia.

December 1975-June 1976: Health Aid, Department of Psychiatry, Brentwood Veterans Administration Hospital. Los Angeles, California.
In this capacity, I was responsible for performing admission physical examinations and periodic medical assessments (under the supervision of the attending psychiatrist) on persons admitted for psychiatric care.

October 1973-June 1976: Inactive duty, U.S. Navy Reserve.
During this time, I served temporary active duty assignments with the Navy Aerospace Medical Institute and Naval Regional Medical Center, Pensacola, Florida; and with the Infectious Disease Service, Naval Regional Medical Center, San Diego, California.

September 1972-December 1973: Laboratory Assistant, Division of Infectious Diseases, Department of Internal Medicine, School of Medicine, University of California, Los Angeles.
In this capacity, I worked with Dr. Lowell Young conducting various studies on the effectiveness of new antibiotics.

August 1970-June 1972: Resident Fireman, Stanford University Fire Department. Stanford, California.

○

ISBN 0-16-046899-X
90000
9 780160 468995